HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

Rev. Msgr. Augustine C. Dalton (see page 5)

Administrator's Digest

Convention Capsules—page 17
Upper Midwest; Southeastern;
Middle Atlantic;
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Long-Term Care Unit: 24 Successful Years

Page 27

CSR Bi-State Group Holds KC Institute

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BUYER'S GUIDE
Page 64

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JULY | 1958

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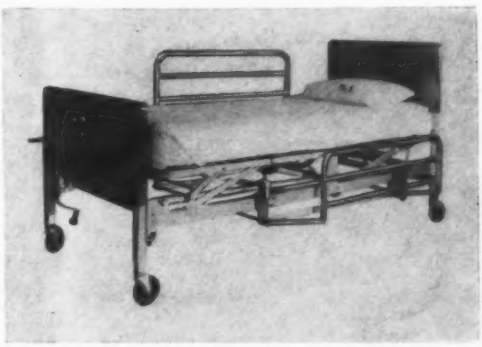

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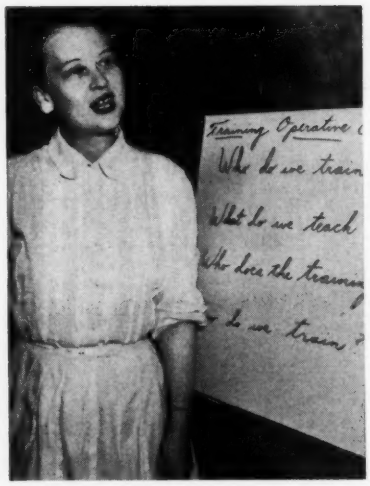
HOSPITAL Topics
GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES
JULY, 1958, VOL. 36, NO. 7



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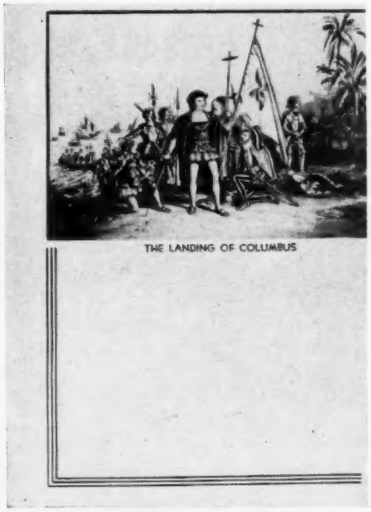

THE LANDING OF COLUMBUS

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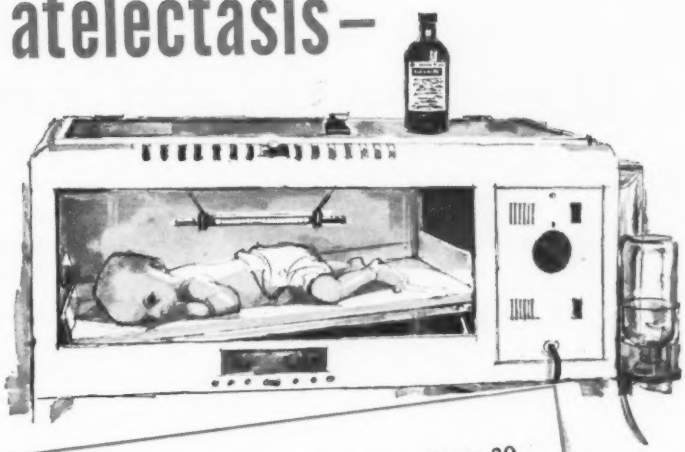

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*Smessaert, Andre; Collins, V. J.; and Kracum, V. D.: New York Jour. Med., 55:1587, June 1, 1955.

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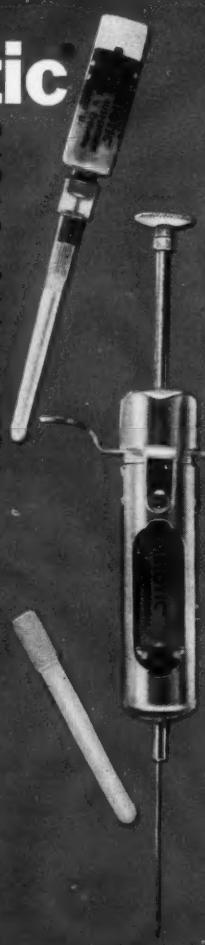

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PERSONALITY OF THE MONTH

FOR almost four decades, the Rt. Rev. Msgr. Augustine C. Dalton, P.A., LL.D., has been a priest of the Archdiocese of Boston, and the last ten of these have been spent as director of hospitals for the Archdiocese. He has now embarked on two major organizational offices. In June he became president of the Catholic Hospital Association, and in May, head of the Massachusetts Hospital Association.

Archbishop Richard J. Cushing of Boston describes Msgr. Dalton as eminently qualified for these responsibilities through his comprehensive understanding of hospital problems and his prudent and discerning insight into the human psychology of hospital administration.

Msgr. Dalton, 62, is a native of Massachusetts, having been born in Braintree. He attended Boston College and St. John's Seminary, Boston, and was ordained in 1920. After serving as an assistant in parish work, he became parish priest at St. Thomas More, Braintree, in 1944.

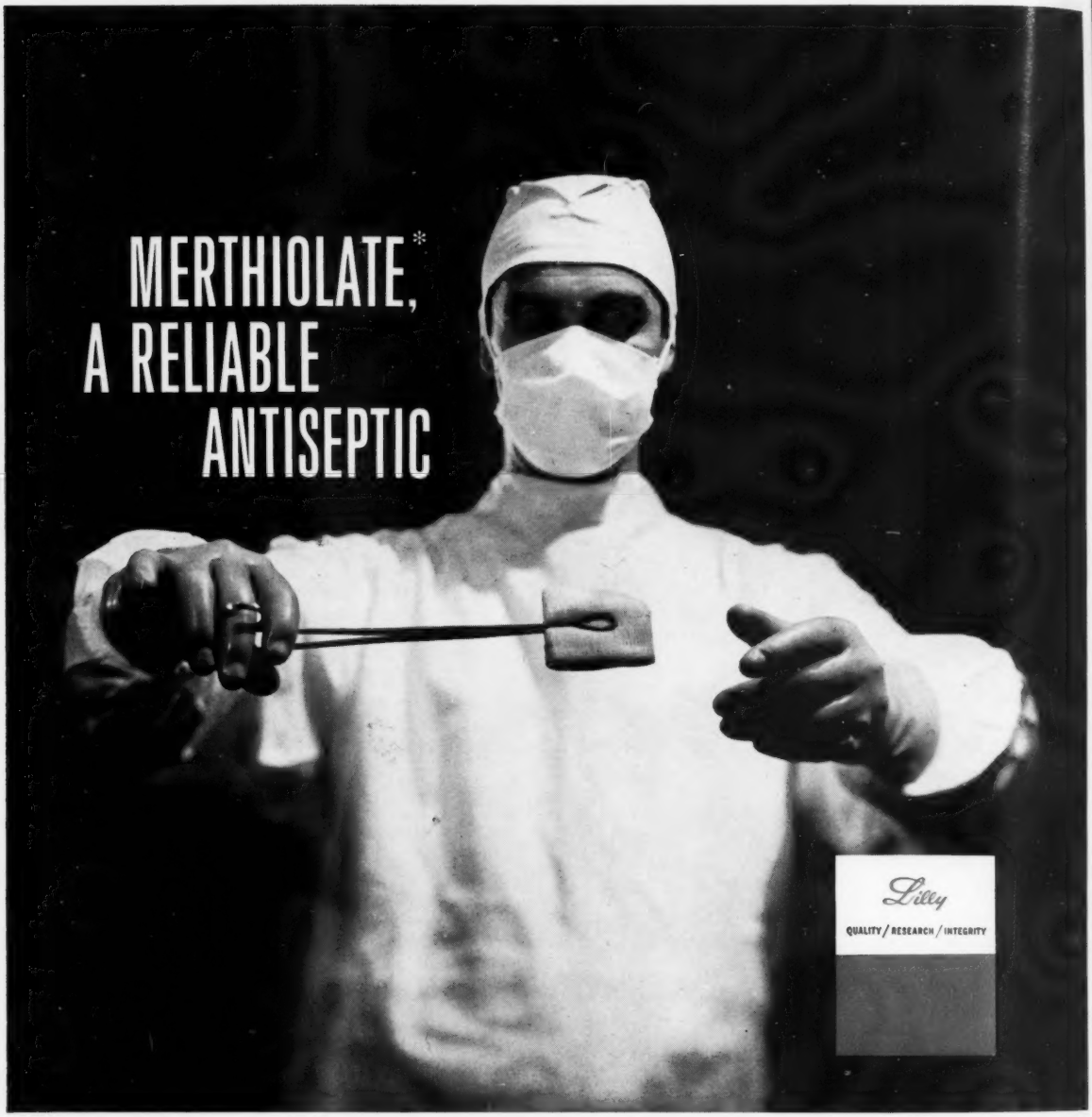
Since 1945 he has been at Dorchester, Mass., where he founded and organized the St. Kevin parish, and directed building of the church, a 16-room school, rectory, and convent.

Special work Msgr. Dalton has done includes organization of both the Diocesan Council of Catholic Nurses and the Archdiocesan Councils of Catholic Men and Women; deanery director, CYO, 1939-44; and lecturer on youth work, St. John's Seminary, 1939-45.

Other activities include membership on Massachusetts Governor Herter's committee to investigate state hospitals, the state committee on public defense, the state advisory health commission, and state commission on hospital costs, and directorship of the U.S. Council of Catholic Nurses.

Articles by Msgr. Dalton on nursing, hospital problems, and medical research have appeared in numerous Catholic publications and in the Massachusetts press.

When he finds time for hobbies, Msgr. Dalton says he enjoys gardening, hi-fi, and "attempting to play a pipe organ."



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HOSPITAL Topics
The News Magazine for the Hospital Staff

JULY, 1958
VOL. 36, NO. 7

Scanning the News

Dogs Don Space Suits, Have Circulation Problems

Nine dogs in space suits have given a hint of the problems of blood circulation in outer space.

The dogs were tested in a space suit, as a prelude to developing a protective suit for man in outer space, at the department of physiology, Ohio State University, Columbus. Investigators E. T. Carter, E. J. Reininger, F. A. Hitchcock, and R. Epps substituted mechanical pressure for that of the normal atmosphere, then determined the dogs' blood pressure at various body points.

The results were reported at the annual meeting of the Federation of American Societies for Experimental Biology. The investigators reported marked depression of cardiac output, a decrease in systemic arterial pressure, and a rise in central venous pressure. The tests suggest that the difficulty might lie in inadequate pressurization of the neck region and extremities.

Poor Eating Habits Affect Mortality Rate

Contrary to popular belief, the U.S. is not the healthiest country in the world, particularly for men in their prime, states Frederick J. Stare, M.D., chairman, department of nutrition, Harvard School of Public Health, Boston.

Speaking at the recent National Food Conference in Washington, D.C., Dr. Stare cited statistics showing that American males past 45 rank tenth in over-all mortality among a list of seventeen countries from which data are available.

In addition, Dr. Stare reported, middle-aged men in the U.S. have the highest death rate from diabetes, and cardiovascular and kidney diseases, among the countries studied.

Proper diet, a good, sound breakfast, and reducing for the obese, a high mortality factor, were steps he urged to prolong life.

Report New Polypeptide Believed Migraine Cause

Isolation of a polypeptide believed to cause migraine headaches was reported by Loring F. Chapman, Ph.D., New York Hospital-Cornell Medical Center, New York City, at the recent annual meeting of the American Academy of Neurology.

Dr. Chapman reported that the polypeptide, which causes pain if dropped on an open blister, dilates blood vessels, permitting them to carry more blood to the brain in moments of stress. In some cases, he added, the polypeptide gains access into the area around the skull, resulting in migraine pain.

Distorted Statistics Bring Fear to Public

A breakdown in doctor-patient communication has brought fear into the lives of the public, warns Lester L. Coleman, M.D., New York City.

He told a meeting of the Medical Exhibitors Association recently that if "we were to believe all the distorted, fear-provoking statistics, this is what our destiny would be like:

"By 1968, one out of every five of us would be dying of cancer, while one out of every 20 would be in a mental institution. We would probably be visited from time to time in the hospital or asylum by one of our children, a victim of cerebral palsy or polio, while our second child would be at home ill with rheumatic fever. The third child would, under these circumstances, be forced to go to his psychiatrist alone."

Dr. Coleman urged that the medical profession and the pharmaceutical industry work together to allay fear of potential illness as well as to rehabilitate victims of disease.

Muscle Moves Fingers For Polio Victims

A tiny, artificial muscle which moves fingers of paralyzed polio patients has been designed by Joseph L. McKibben, Ph.D., atomic physicist, in conjunction with Vernon Nickell, M.D., chief orthopedist, Rancho Los Amigos Respirator Center, Los Angeles.

The device was demonstrated at a conference on human disability sponsored by the New York Academy of Sciences.

The device consists of a tube of braided plastic. Gas pressure causes the tube to expand and contract. This closes a paralyzed hand by actuating a splint affixed to the first and second fingers and thumb.

The paralyzed person can actuate the device by turning a three-way valve through which the pressure opens, closes, or holds the fingers. The valve can be worked by the patient's residual muscles, even the tongue muscle.

A cylinder of carbon dioxide, two inches in diameter and 14 inches long, can power the new device for two or three months.

News Briefs at Press Time

SURVEY FINDS NURSE SALARIES VARY WITH GEOGRAPHIC LOCALE

Average weekly earnings of directors of nurses range from $120.50 in Minneapolis-St. Paul to $95.50 in Baltimore, according to a survey conducted by the U. S. Bureau of Labor Statistics. For supervisors, highest average weekly earnings were also in Minneapolis-St. Paul—$88. Lowest were in Philadelphia, $70.50.

Nursing instructors' average weekly earnings were $92 in San Francisco-Oakland, and $71 in Memphis. Head nurses averaged $81 weekly in Minneapolis-St. Paul to $63 in Philadelphia.

NEW YORK, MICHIGAN BLUE CROSS PLANS TAKE EMERGENCY ACTION

Two states—New York and Michigan—took emergency action last month when faced with mounting financial crisis in Blue Cross.

Associated Hospital Service of New York, which serves 7 million subscribers in New York City area, asked State Insurance Superintendent Julius S. Wikler for 40 percent rate boost, got a 22.3 percent increase. AHS contended it was losing $75,000 a day under present rates.

Michigan Blue Cross board of directors clamped a ceiling on payments to hospitals for remainder of 1958, voting to hold payments per day of patient care to a maximum of 4 percent over their 1957 cost. Also, final Blue Cross payments to all participating hospitals will be cut another 1 percent, whether or not costs reach the 104 percent ceiling.

Michigan action, recommended by a majority of state's 230 Blue Cross member hospitals, is intended as a temporary measure to forestall a rate increase or decrease in benefits.

New York rate increase, which AHS termed "insufficient," was granted following two-day public hearing held by State Insurance Department.

Both plans are seeking long-range solutions to problems. In New York, the state's 19 Blue Cross, Blue Shield and dental expense indemnity plans agreed to pay for a year-long survey of their operations by Columbia U. School of Public Health and Administrative Medicine. Michigan Blue Cross has appointed a special study commission.

COMPLAINTS AGAINST DUBIOUS DRUGS AND DEVICES ARE INCREASING

Food and Drug Administration enforcement agents are being hard pressed to keep up with increasing complaints involving questionable medicinals and do-it-yourself therapeutic devices. April report revealed that of 24 seizures during the month, 17 were alleged to have been exploited with false and misleading claims.

Wide variety of products pounced on by FDA included "royal jelly" preparations for rejuvenation of the aged, soybean products sold as treatments for gallstones and ulcers, mineral compounds peddled as syphilis cures, laxative herbs for stomach disorders, electric massage pillows "guaranteed" to reduce weight.

Meanwhile Federal Trade Commission, which watchdogs advertising claims while FDA looks to labeling and accompanying literature, has kept busy with such cases as misrepresentation of glasses and spectacles, claims by hair experts which three dermatologists testified are false.

FTC's appeal for jurisdiction over health insurance advertising expected to get Supreme Court ruling soon.

APPROPRIATIONS BILL VOTES BIG INCREASES FOR MEDICAL RESEARCH GRANT

Budgetary increases of unprecedented size for support of medical research are contained in committee-approved appropriations bill for Department of HEW.

Bill recommends $81.1 million for National Cancer Institute, about 45 percent more than White House requested. Corresponding raises have been given mental health—$55.9 million; heart—$49.5 million; allergy and infectious diseases—$26.5 million; neurology and blindness—$32.2 million.

Over-all USPHS budget is raised to $807.4 million, compared with $562.7 million being spent in current year, and $568.3 million recommended by White House.

Senate Appropriations Committee also recommended maximum sum of $211.2 million for Hill-Burton hospital construction grants.

Gordon M. Marshall

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Calendar of Meetings

JULY

1- 3 American Hospital Association Institute, Hospital Law, Cosmopolitan Hotel, Denver

1-15 International College of Surgeons, Eastern Regional Meeting, Equinox House, Manchester, Vt.

13-18 American Association of Hospital Accountants, Annual Institute on Hospital Accounting and Finance, Indiana University School of Business, Bloomington

14-18 American Hospital Association Institute, Hospital Purchasing, Michigan State University, East Lansing

28-August 1 American Hospital Association Institute, Hospital Pharmacy, University of Chicago, Chicago

AUGUST

4- 8 American Osteopathic Hospital Association, Medical Record Librarians Training School, University of Colorado, Boulder

15-20 World Medical Association, Copenhagen, Denmark

16-18 American College of Hospital Administrators, Annual Meeting, International Amphitheatre; Convocation, Orchestra Hall, Chicago

18-21 American Hospital Association, International Amphitheatre, Chicago

24-29 American Congress of Physical Medicine and Rehabilitation, Philadelphia

SEPTEMBER

7-11 American Surgical Trade Association, Shoreham Hotel, Washington, D.C.

8-12 AHA Institute, Dietary Department Administration, Bellerive Hotel, Kansas City, Mo.

15-16 Montana Hospital Association, Havre

15-17 AHA Institute, Disaster Planning, Adolphus Hotel, Dallas, Tex.

18-19 American Osteopathic Hospital Association, Northwest Institute, New Heathman Hotel, Portland, Ore.

22-25 AHA Institute, Evening and Night Nursing Service Administration, Sheraton-Lincoln Hotel, Indianapolis

25-26 AHA Institute, Hospital Insurance, Capitol House, Baton Rouge, La.

28-Oct. 1 American Fracture Association, Oklahoma City, Okla.

29-Oct. 2 AHA Institute, Operating Room Administration, Sheraton-McAlpin Hotel, N. Y.

29-Oct. 2 AHA Institute, Medical-Social Workers, Hotel Radisson, Minneapolis

OCTOBER

6-10 American College of Surgeons, Conrad Hilton Hotel, Chicago

8- 9 Indiana Hospital Association, Indiana University Student Union Building, Indianapolis

8- 9 Vermont Hospital Association, Hotel Vermont, Burlington

12-17 American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago

13-16 American Association of Medical Record Librarians, Statler Hotel, Boston

15-16 Washington State Hospital Association, Winthrop Hotel, Tacoma

(Continued on page 12)

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CALENDAR

(Continued from page 10)

15-17 Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask., Canada

16-18 West Virginia Hospital Association, Daniel Boone Hotel, Charleston

20-21 Idaho Hospital Association, Elks Temple, Boise

20-23 American Academy of Pediatrics, Palmer House, Chicago

20-24 National Safety Council, Conrad Hilton Hotel, Chicago

21-23 American Dietetic Association, Trade and Convention Center, Philadelphia

21-23 Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alb., Canada

21-24 American Society of Anesthesiologists, Penn Sheraton Hotel, Pittsburgh

22-24 California Hospital Association, Biltmore & Miramar Hotels, Santa Barbara

23-24 Mississippi Hospital Association, Hotel Heidelberg, Jackson

23-24 Nebraska Hospital Association, Omaha

24-28 American Heart Association, Civic Auditorium, San Francisco

25 American College of Osteopathic Hospital Administrators, National Institute, Statler Hotel, Boston

26-29 American Osteopathic Hospital Association, Statler Hotel, Boston

27-31 American Public Health Association, Kiel Auditorium, St. Louis

28-31 British Columbia Hospital Association, Vancouver Hotel, Vancouver, B.C., Canada

NOVEMBER

1- 8 American Society of Clinical Pathologists, Congress Hotel, Chicago

3- 5 Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D. C.

6- 7 Oklahoma Hospital Association, Skirvin Hotel, Oklahoma City

7 Minnesota Hospital Association, Lowry Hotel, St. Paul

10-13 Interstate Postgraduate Medical Assembly of N.A., Public Auditorium, Cleveland

10-14 American Association of Inhalation Therapists, Kingsway-Ambassador Hotel, St. Louis

13-14 Arizona Hospital Association, Westward-Ho Hotel, Phoenix

13-14 Kansas Hospital Association, Baker Hotel, Hutchinson

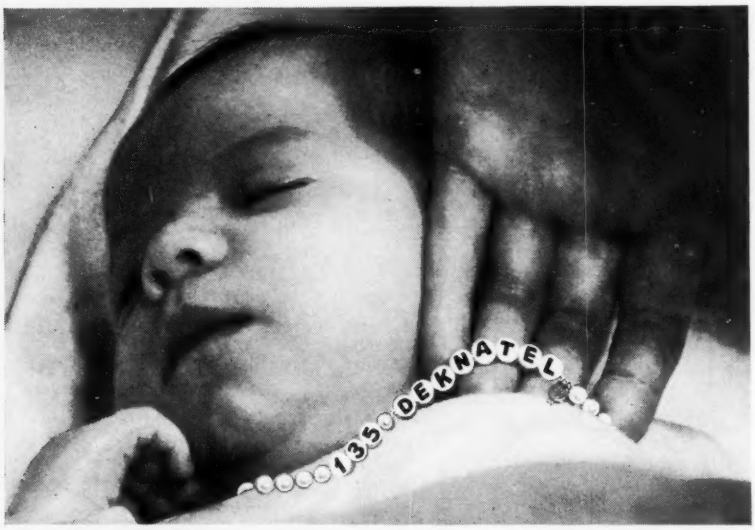
14-16 Virginia Hospital Association, Hotel Roanoke, Roanoke

17-18 International College of Surgeons, Mid-Atlantic Meeting, Homestead Spa, Hot Springs, Va.

17-19 Association of Military Surgeons of the U. S., Hotel Statler, Washington, D. C.

19-21 Missouri Hospital Association, President Hotel, Kansas City, Mo.

20-22 American Association of Blood Banks, Netherlands Plaza Hotel, Cincinnati



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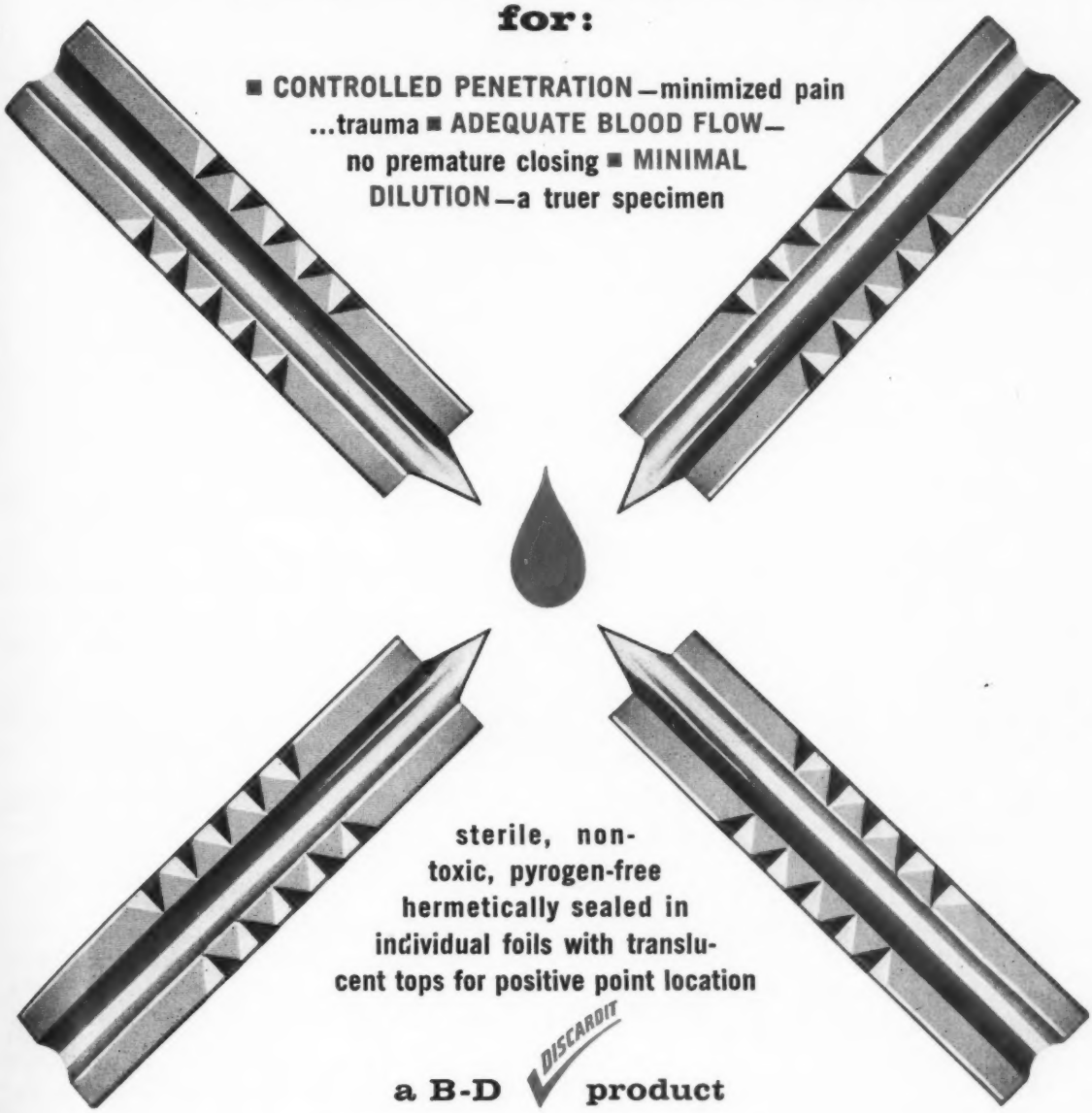

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† Reports of laboratory tests retained in files of Davol Rubber Company

* **FREE:** A test supply of 4 oz. Feed-Rite Nursers with nipple covers will be sent to Nursery Supervisors or Hospital Administrators on request. Write to: Davol Rubber Company, Providence 2, R. I. (on institution stationery), or contact your hospital supply dealer.

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Amazing properties of new polyethylene make Davol Feed-Rite Nurser ideal for true hospital method of terminal sterilization.

FEED-RITE PLASTIC NURSERS and formula can be terminally sterilized (all at once) under live-steam pressure with the nipples fully covered, in an upright position, ready for feeding. WILL NOT BREAK, CRACK, WARP OR DISTORT.

ORDINARY PLASTIC NEW FEED-RITE

MARLEX rigid polyethylene opens a new era in plastics, with numerous advantages over conventional materials now in hospital use.

- **VIRTUALLY INDESTRUCTIBLE** . . . Products made of MARLEX plastic are tough and strong! Throw the FEED-RITE NURSER on the floor, step on it . . . try to crush or break it, and you'll see what we mean.
- **BETTER TEMPERATURE RESISTANCE** . . . You can freeze MARLEX at temperatures as low as 180° F. below zero without damaging it . . . and heat it up to as high as 250° F.! You can boil or steam-sterilize the FEED-RITE NURSER and other MARLEX products.
- **EASY TO CLEAN** . . . The hard, glossy surface of this new material has superior abrasion resistance and is very easy to clean and maintain.
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- **LIGHT WEIGHT** . . . FEED-RITE NURSERS are easy to hold, comfortable to touch. Most MARLEX products are lighter weight than conventional materials.
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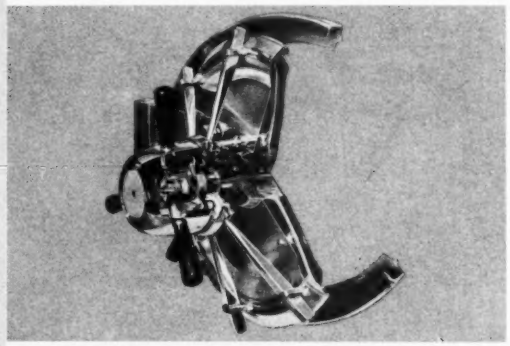

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Convention Capsules

Upper Midwest Hospital Conference--

Minneapolis, May 14-16

Administration Research

Research in Hospital Administration Key to Future Development

Research in hospital administration has not kept pace with general progress in the hospital field.

Reasons for the present poor status of research in administration are: (1) failure to appreciate the potential contributions of research; (2) insufficient awareness of the problems in practice; (3) failure to appreciate the value of increased knowledge in administration and the social sciences; (4) failure to support research; (5) lack of skilled persons in the hospital field.

Stimulation and promotion of research programs require basic knowledge of the field, formulation of questions or hypotheses, development of methods, personnel, laboratories, finances, and support.

Relatively little progress has been made in developing scientific technics for testing and validating existing practices or in discovering and testing new ideas and methods. Research to date is too preoccupied with description and "first questions." It ignores the second or analytical questions such as: "What is the emerging role of semi-professional personnel in hospitals? What are the consequences? What are the causes?"

Follow-through from the description or how-to-do-it level of research to investigation of the second questions raised is sorely needed in the hospital field.—*John Y. James*, director, Association of University Programs in Hospital Administration, Graduate School of Public Health, University of Pittsburgh, Pa.

Financing

Planning, Public Relations, Flexibility Necessary to Meet Future Needs

While the total economy will be competent to provide the necessary funds for hospital expansion during the coming years, getting the full share for hospital needs will be another matter. Health and hospital projects currently receive only about 1/7 of the total gift dollar. To finance the needs of future years, hospitals must achieve a larger percentage.

Added to expansion and replacement requirements will be a need for costly diagnostic, electronic, therapeutic, and other technical devices, as general hospitals become medical centers for the immediate areas they serve. Fund-raising will undergo further changes; the short intensive campaign may expand into a long-range continuing effort.

Governing boards and administrators must improve operations if maximum financial support is to be achieved. Internal operations and practices should be tightened. Be flexible, within reason, in meeting new developments and situations. Participate in sensible planning. Hospital expansion must be planned to meet the community's total needs, not the particular interests of a few individuals.

Practice good public relations. This means the administrator, board, medical staff, and employees should participate in a planned program of information and cultivation of the public in the good work which the hospital does, its contributions to the community, its problems and aims.

Financing of hospital needs can be met most practically and economically through voluntary philanthropy. This is the major source of financing for the nonprofit community general hospital. Hospitals themselves, through good management and sound business practices, may be expected to assume a greater portion of the total cost than has been previously possible. Organized labor is a lucrative source of philanthropy which has not yet been tapped.—*Robert A. Dobbin*, vice-president, American City Bureau, Chicago.

Housekeeping

Establish Four-Year Degree Program In Housekeeping Administration

As a result of an increasing demand for educated, well-trained executive housekeepers, the Puget Sound chapter of the National Executive Housekeeper's Association undertook a pilot study on a four-year degree course and internship program.

This study resulted in establishment of a curriculum in institution administration at the University of Washington, Seattle, leading to a Bachelor of Science degree in home economics.

Objectives of the degree program include enabling the student to develop: the necessary knowledge, understanding, and skill essential for effective administration of a housekeeping department; an understanding of operation and inter-relationships of hospital departments; leadership ability; understanding about micro-organisms and their control; ability to conduct a testing laboratory for textiles, supplies, and equipment; ability to keep records

(Continued on next page)

Above: Donald W. Cordes (l.), administrator, Iowa Methodist Hospital, Des Moines, outgoing president, Upper Midwest Hospital Conference, stops for picture with new president, Harold C. Mickey, director, Rochester (Minn.) Methodist Hospital, and Richard Lubben, administrator, Bozeman (Mont.) Deaconess Hospital, president-elect.

and prepare necessary budgets and reports, and ability to purchase wisely.

The curriculum covers such courses as administration, human relations, personnel management, textile supplies and equipment, budgets and recording, sanitation, chemistry, microbiology, and purchasing. Students who intend to become members of the National Executive Housekeeper's Association must take a year's internship in an approved hospital housekeeping course after completing the program.—*Madge H. Sidney*, director of housekeeping, The Doctors Hospital, Seattle, Wash.

Medical Records

Group Indexing System Provides Space, Time, and Card Economy

After six years of classifying each disease or operative procedure on a separate disease or operative card, a survey revealed these facts: Of the total 1,297 cards in our visible index file, 303 (23 percent) contained frequent postings and represented 77 diseases or operations; 685 (52 percent) contained two or fewer entries a year, and 123 cards contained only three or four entries.

We adopted a system of group indexing whereby a card was set up according to the first two digits of the code number for each topographical region. A separate column permitted entry of the complete anatomical code number, and 11 additional columns were included for recording the etiological code numbers plus other pertinent information.

Adoption of this system provided an economy of space, cards, and time required for posting. The posting was less detailed and could be done by less well-trained clerks. The system made it very simple to locate codes for any specific disease or operative procedure for group studies.—*Sister Mary Karline, O.S.F., R.R.L.*, St. Francis Hospital, Breckenridge, Minn.

MEMO TO:

THE PURCHASING AGENT

Been wanting to cut costs and inventories, yet get the best supplies possible for cleaning and disinfecting?

Turn to page 37

Two-Year Program

Graduates of Two-Year Curriculum Well-Prepared as Bedside Nurses

Results of five years' experience with the two-year nursing curriculum indicate that this type of program can prepare a nurse to perform those functions commonly associated with the registered nurse. The program can become an integral part of a total college program, and can be financed just as any other college program is financed.

Seven community junior colleges were selected to co-operate in the research project. They represented different sections of the country, were of various sizes, had different sources of support, and different curriculum patterns. One hospital school also was included in the project.

General education accounts for one-third of the total curriculum, while nursing accounts for about two thirds.

Of the nursing portion, 75 percent is clinical experience. Emphasis is on giving the student all of the experience needed to become a nurse.

The method of planning and instructional supervision makes possible more effective use of time spent in the clinical field; hence a shorter period of time is taken to produce the same product as that of a hospital school.

Students qualify for the associate degree and are eligible for the licensing examination of the state in which the college is located.

Eight hundred and eleven students have been admitted to the eight programs. As of October, 1956, the drop-out rate was 20.5 percent. The reasons for drop-out seem to resemble the pattern of college education rather than nursing education.

Graduates from six programs number 234. One hundred and ninety-two students have taken licensing examinations; 91.7 percent of these passed the examinations the first time. In nursing programs of all types, the figure is 90.5 percent.

Graduates were found by head nurses to be as good as most or better than most of the graduates with whom they worked in 80 percent of the cases. The graduates themselves were well-satisfied with their preparation.—*Mildred Montag*, associated professor, nursing education. Teachers College, Columbia University, New York City.

Southeastern Hospital Conference--

Miami Beach, May 14-16

Nursing Administration

Meet Need for Nursing Management By Advanced Courses in Technics

The importance of administration should be emphasized in the nursing education curriculum; the student should understand that nursing and administration must go hand in hand.

This does not mean developing a basic nursing program that will produce nurse administrators. We need and want nurses who are dedicated to tender, loving care, but we also want good management. We believe that intensive training in supervisory skills can be superimposed upon the foundations of nursing, and that these skills can be developed among existing personnel through in-service programs.

The hospital's greatest weakness in operational efficiency is in the nursing department, which employs 50 percent or more of the institution's personnel. To better utilize current nursing personnel, graduate nurses have been relieved of detail, but they still tend to resist responsibility and leadership, and full utilization of nonprofessional personnel. Varying percentages of intensive care can frequently be given by nurse aides or practical nurses. Functions requiring highly developed skills, accompanied by a need for the exercise of judgment, must be assumed by the professional nurse.

The answer to the dual need for devoted patient care, with its close, warm, and personal association with the patient, and for good management can be found in the establishment of short intensive courses in management technics to selected nurses who have aptitudes for supervision and management.

A pattern to provide nursing managers should include:

(1) Helping hospitals to provide in-service programs in supervision to head nurses and nursing supervisors.

(2) Developing a plan for testing students in degree and diploma schools to determine their aptitude for management and leadership.

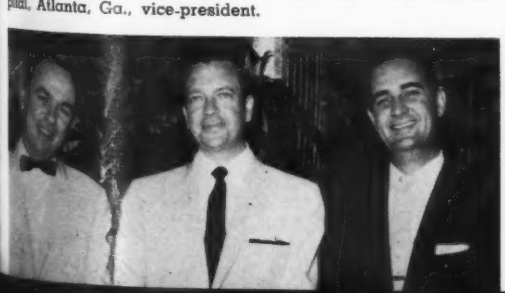
(3) Providing flexibility in university programs so that senior students with high aptitude for management might have a specialized program conducted by teachers of management.

(4) Providing intensive university summer courses in management technics for selected nurses who are now or who want to be head nurses.

(5) Giving nursing students instruction from hospital administration in the relationship of the nurses as a whole.

Instruction in all cases should be by teachers of management, rather than by nursing instructors. —*Lester E. Richwagen,* administrator, and *Philip E. Day, R.N.,* director of nursing service, Mary Fletcher Hospital, Burlington, Vt.

New officers of the Southeastern Hospital Conference are (l. to r.): Charles W. Flynn, Jackson, Miss., executive director, Mississippi Hospital Association, executive secretary; Robert A. Ivy, administrator, Doster Hospital and Clinic, Columbus, Miss., president, and Oscar S. Hilliard, administrator, Tri-County Hospital, Fort Oglethorpe, Ga., president-elect. Absent from the picture is George Burt, administrator, Piedmont Hospital, Atlanta, Ga., vice-president.



Nursing Education

Urges Setting Up Degree Program In Hospital Nursing Schools

A random sampling of administrators, medical staffs, and nurses, including supervisors and nursing directors, reveals that graduates of hospital schools of nursing are more competent in patient care than are those coming from collegiate schools.

Hospital school diploma programs provide learning experiences that are more functionally and realistically related to the competencies, skills, and knowledge involved in patient care, but some nursing leaders have looked unfavorably upon the diploma program. Nurses have been made to feel that they are not professional unless they have a college degree.

The number of hospital schools has dropped from 1,190 to 768 in the last eight years. College and university graduates will not be sufficient to staff the hospitals of tomorrow.

The answer lies in setting up nurses' colleges similar to teachers' colleges, built out of the hospital schools of nursing. They should be licensed to grant the degree of bachelor of nursing. The entire curriculum should be tailored to the needs of the nurse as a bedside practitioner, with academic courses integrated into functional units of instruction related to the problems of patient condition and care.

These hospital nurses' colleges would not offer graduate courses leading to master's or doctorate degrees. University schools of nursing would expand their graduate nursing education to provide programs for nursing instructors, researchers, public health workers, college professors, and organizational leaders. Such courses would be more meaning-

(Continued on next page)

Pictured at top are two of the new officers, Southeastern Hospital Conference of Dietitians. They are Mrs. Myrtle M. Vincent (l.), director of dietetic services, U.S. PHS Hospital, New Orleans, president, and Gwendolyn Biggerstaff, dietitian, Kennestone Hospital, Marietta, Ga., president-elect. Directly above are the new Southeastern Hospital Pharmacists officers (l. to r.): Jack C. Kirkland, pharmacist in charge, Memorial Medical Center, Williamson W. Va., president; Perry E. Cox, director of pharmacy and central services, Carraway Methodist Hospital, Birmingham, Ala., secretary-treasurer; and James W. Mitchener, chief pharmacist, Cabarrus Memorial Hospital, Concord, N. C., vice-president.

SOUTHEASTERN continued

ful if undertaken after the nurse has some experience, and has shown interest and ability in specialized functions.—*Dana Hudson, R.N.*, director, School of Nursing, Georgia Baptist Hospital, Atlanta, Ga.

Food Service

Use Hospital Meal Service As Public Relations Tool

Through meal service, dietitians contact every patient in a hospital and accordingly are the best public relations tools on the hospital staff. It might be well for hospitals to evaluate their meal service in the light of public relations, as do air lines.

While hospitals may not be able to hire whom they want because of the low wage levels and unconventional work hours, they can concentrate on making the best of what is available. Individuals will perform better if they feel part of a successful operation.

Service and appearance of a meal are as important as preparation, nutrition, and balance. People who serve food to patients should be encouraged to greet patients cheerfully, with a smile, rather than to indifferently drop a tray at a bedside. Through their attitude, they can make the patient forget the assembly line operation of hospital food service and cause him to feel that the food was prepared especially for him.

Valid requests to the administration for increased personnel or facilities will do much to aid good food service. Trade magazines and food merchandising periodicals provide numerous ideas on new products and methods of preparing and handling foods. Use imagination. Gimmicks, not necessarily costly, can be used to show the patient that thought has gone into preparation of his meal. —*John L. Sutton*, passenger superintendent, Delta Air Lines, Inc., Atlanta, Ga.

Nursing Service

Nursing Service Evaluation Results In Better Use of Personnel

The division of nursing resources has assisted more than 70 hospitals in evaluating nursing service needs. Results of a nursing activity study at the Jackson-Madison County General Hospital, Jackson, Tenn., were as follows.

A ward manager category was established on one wing to relieve the head nurse of ordering supplies, of keeping equipment available and in working order, and of maintaining the physical appearance of the unit.

The hospital PBX operator now can call directly to the patient's room; formerly the nurse had to go tell the patient to answer the phone.

More ward clerks were hired to relieve registered nurses of a large amount of clerical work.

A nursing study committee was established to improve nursing service by reviewing and investigating nursing problems.

A pilot study was begun on two units to consider changing the drug system; all units now have been converted to the new drug system.

It is important that both administration and nursing personnel desire and plan together for an

Below, left: Newly elected officers, Southeastern Medical Record Librarians are (l. to r.): Hildegard M. Mayer, medical record librarian, Winter Park (Fla.) Memorial Hospital, secretary; Caroline N. Moscrip, medical record librarian, Orange Memorial Hospital, Orlando, Fla., treasurer; Mrs. Marion J. Cowden, chief medical record librarian, Huey P. Long Charity Hospital, Pineville, La., president; and Charlsie Jennings, medical record librarian, Greenwood (Miss.) LeFlore Hospital, president-elect. Nurse Anesthetists officers, below, right, are (l. to r.): Mrs. Georgie Regan, chief anesthetist, Beacham Memorial Hospital, Magnolia, Miss., chairman; Mrs. Alberta Shurley, anesthetist, McComb (Miss.) City Hospital, secretary-treasurer; and Thomas Parker, chief anesthetist, Leeds (Ala.) Hospital, chairman-elect.

objective study of nursing personnel activities. The best approach is to train hospital personnel to make such studies themselves and to observe their own situations. Subsequent suggestions for changes are more readily accepted when those affected have participated in steps which revealed the need for improvement. —*Apollonia O. Adams*, chief, Division of Nursing Resources, U.S. Public Health Service.

Practical Nurses

Train Practical Nurses To Assure Service of Superior Quality

The rapidly growing corps of trained practical nurses should be sufficiently well-prepared to be assigned to full patient care. Variations in standards between schools in different states and within the same state is a major problem. Licensing laws do not always encourage the development of good schools as they should.

Curriculum content, physical facilities, clinical experience, and selection of students should uniformly be of such excellence that hospital administrators could be assured patient safety and nursing service of superior quality would accompany employment of trained practical nurse personnel.

We find trained practical nurses serving as charge nurses after 3 p.m. and carrying the entire responsibility of a ward but, in the same hospital, they are not allowed to chart or give medicines from 7 a.m. to 3 p.m. This is a recognition of service shortage, not practical nurse ability. Think what it would mean in service hours to hospitals if well-prepared practical nurses could give this expanded service at 7 a.m. as well as at 3 p.m.

A sense of personal worth, a career prestige value, a recognition of ability, and increased responsibilities have been found to be more important than salary in keeping practical nurses in the field.—*Wilda M. Torrop*, executive director, National Association for Practical Nurse Education, New York City.

Middle Atlantic Hospital Assembly--

Atlantic City, May 21-23

• Compulsory health insurance for the aged, rising costs of hospital care, preventive medicine, and medico-legal liability were among subjects discussed at the 10th annual Middle Atlantic Assembly, attended by almost 4,000 hospital people.

Discussing future patterns of health care, Aims C. McGuinness, M.D., special assistant to the secretary for health and medical affairs, U.S. Department of Health, Education, and Welfare, said that the demand for general hospital beds can be reduced and the cost of hospitalization to many patients can be lowered only if hospitals recognize the importance of preventive medicine, rehabilitation, and the care of the ambulatory patient.

Voluntary health insurance offers the best means of helping most people meet the costs of health care, added Dr. McGuinness.

Taking an opposite view that "Commercial health insurance . . . is highly unreliable," Mrs. Katherine Ellickson, assistant director, AFL-CIO department of Social Security, said: "It can be lost not only by discharge or other cessation of employment, but by cancellation."

She noted that while the AFL-CIO supports the Forand bill (H. R. 9467), which proposes providing insurance against the cost of hospital, nursing home, and surgical services to persons eligible for old-age and survivors benefits, the union organization is not necessarily committed to all its details.

Edward L. Bortz, M.D., a past president of the American Hospital Association, felt that federal health insurance would just about wipe out voluntary health insurance companies and Blue Cross as well. He warned that socialization of the health and insurance professions would lead to eventual socialization of all professions.

Speaking of the rising costs of hospital care, Abram L. VanHorn, M.D., new president of the New Jersey Hospital Association, urged hospital officials to make strenuous efforts to economize in all areas and to streamline their operations if they are to avoid regulatory measures which would be destructive to the voluntary hospital system.

Newly elected officers of the Middle Atlantic Hospital Assembly are Ambrose P. Merrill, M.D., superintendent, St. Barnabas Hospital for Chronic Diseases, New York City, president; James C. Kirk, administrator, Pottsville (Pa.) Hospital, vice-president; John F. Worman, executive director, Hospital Association of Pennsylvania, re-elected treasurer; J. Harold Johnson, executive director, New Jersey Hospital Association, re-elected secretary.

MEMO TO:

THE ADMINISTRATOR

Been wishing you could do <u>all</u> the things needed to control cross infection--yet keep labor and material costs down too?

Turn to page 37

American Nurse's Association--

Atlantic City, June 9-13

A grandniece of Louis Pasteur is the new president of the National Student Nurses' Association. She is Lynda Goodier (seated, center), student at Mercy Hospital School of Nursing, New Orleans. Other officers are (seated, l. to r.): Christine McGuirk, Mount Auburn Hospital School of Nursing, Cambridge, Mass., first vice-president; Miss Goodier; Marlene Kelm, Deaconess Hospital School of Nursing, Grand Forks, N. D., second vice-president. Standing (l. to r.): Shirley Katrobus, University of Virginia School of Nursing, Charlottesville, recording secretary; Lee Rasmussen, Duke University School of Nursing, Durham, N. C., corresponding secretary; Paul Spear, St. Francis Hospital School of Nursing, Columbus, O., treasurer.

• Nurses turned out, some 10,000 strong, for the 41st annual convention of the American Nurses' Association in Atlantic City, June 9-13. A small shoe store near the convention hall did a booming business in playshoes for women with boardwalk-weary feet. Technical exhibitors looked ruefully at their empty shelves after a charming horde of student nurses had descended upon the hall, armed with large boxes for more effective sample-collecting.

After a hot debate, the 1,350 members of the ANA House of Delegates approved an increase in annual dues, from $5 to $7.50 instead of the $10 requested. On the first ballot on the increase, it was announced from the platform, there were more votes than there were delegates accredited. When a new ballot was taken, the necessary majority was obtained for approval of the raise.

The ANA says it will use the additional revenue to expand programs and services requested by members.

In other major actions, the delegates:

• Endorsed extension of federal social security to include health insurance for beneficiaries of old-age, survivors, and disability insurance;

• Recommended that constitutent state groups form committees to prevent unauthorized and improper practice of nursing in the state;

• Called upon the American Hospital Association to join the ANA in implementing in all hospitals the essential procedures of collective bargaining, including: 1) freedom of employees to organize; 2) free choice of representation; 3) recognition of employee representatives, and bargaining in good faith by both parties; 4) negotiation of an agreement signed by both parties.

Three presidents snapped during a program intermission (l. to r.) are: Gen. Alfred M. Gruenther, Washington, D. C., president, American Red Cross; Agnes Ohlson, R.N., Hartford, Conn., outgoing ANA president; and David B. Allman, M.D., Atlantic City, N. J., then president, American Medical Association. General Gruenther addressed the convention.

Nurses' Salaries

Nurse Called 'Low Woman on Totem Pole' When Salaries Are Compared

Salaries of nurses have not risen in proportion to the shortage of their professional skills. Economically speaking, when compared with persons in the similar professions of teaching and social work, the nurse is the low woman on the totem pole.

The starting salary for general-duty nurses in some states during 1957 was $250 a month, or $3,000 a year. It ranged to a high of $350 a month, or $4,200 a year. The average salary for teachers in 1957 ranged from $4,200 to $6,200.

It is estimated that some 70,000 additional qualified nurses could have found jobs in 1956. Would-be and should-be nurses go on strike by not becoming or not remaining nurses.

Among the reasons for the nurses' failure to secure a larger share of the national income pie are:

(1) Nurses share in the general reluctance or inability of white-collar workers to encore their demands.

(2) Nurses are employed for the most part by philanthropic and nonprofit institutions and are expected to be both philanthropic and nonprofit themselves.

(3) Nurses share the "American dream" and aspire to something beyond their immediate grasp. As professionals, they feel they must "go it alone."

(4) Nurses have a sense of responsibility for their patients and therefore do not ask for salary increases which may have to come from increases in patient fees.

(5) Nurses "want to be loved." They do not like the public image of organized labor. On the other hand, they do not have enough faith in their own professional dignity or in their own value to society to work collectively for their own welfare. They fail to see that other professional groups have developed a strong collective policy for *their* own welfare.

(6) Most nurses are women—and belittle themselves because of their own personal insecurity.

In at least six states and one territory in which the state nurses' associations have actively supported the ANA's Economic Security program, collective bargaining agreements have been entered into between hospitals and representatives of the state associations.—*Theresa Wolfson, Ph.D.*, consultant to the Economic Security unit, American Nurses' Association, and professor of economics, Brooklyn College, New York City.

Mrs. Fay O. Wilson, R.N. (l.), nursing instructor, East Los Angeles Junior College, receives the Mary Mahoney award from ANA president Agnes Ohlson. The award, made for outstanding leadership in promoting minority group integration, is named after America's first Negro professional nurse. Mrs. Wilson has been instrumental in achieving the acceptance and appointment of minority group nurses and the upgrading of minority personnel on merit, in the Los Angeles County General Hospital.

Nursing Alcoholics

Nurse Has Great Opportunity To Aid Alcoholic in Recovery

Treatments of alcoholism based on the assumption that it is primarily a physiological disorder are certain to fail. Alcoholism is a complex individual and social disorder which affects a complete cross-section of American society.

The healing professions have been reluctant to devote time to a disorder which experience has led them to believe will be unproductive. Feelings of futility toward accepting the alcoholic for treatment result in frustration not only for the therapist, but project failure to the patient himself.

The nurse is in a particularly advantageous posi-

(Continued on next page)

New ANA officers shown at the close of the convention are (l. to r.): Julie M. Carnahan, R.N., New Orleans, La., secretary; Alice Topzant, R.N., Milwaukee, Wis., re-elected treasurer; Mrs. Frieda B. Erhardt, R.N., Phoenix, Ariz., first vice-president; Mathilda Scheuer, R.N., Philadelphia, president; Frances L. A. Powell, R.N., Chicago, second vice-president; and Frederick H. Wescoe, R.N., Cincinnati, O., third vice-president.

tion to help the alcoholic overcome his own self-recrimination and to approach him without reflecting the criticism which he expects. Unlike the physician, the clergyman, and some social workers, the nurse is not an authoritarian figure for the alcoholic. She can exhibit concern for recovery of patients who may feel unworthy because of past relapses.

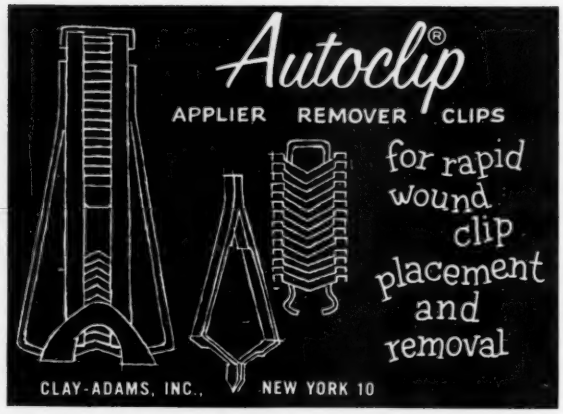
This public-health problem will remain at a stalemate, however, if nurses and others accept the misconception that alcoholism is a self-imposed illness, that the patient is irresponsible in matters of personal hygiene as well as in social relations, that he is entitled only to minimal medical services for overindulgence.

The industrial nurse is in a position to observe progression of alcoholism among workers who exhibit "Monday morning absences" or who seek mild sedatives for relief of hangover. She can discreetly make available helpful literature and suggest early diagnosis and treatment.

The hospital nurse should be alert to symptoms of alcoholism among patients under treatment for other illnesses. There is a very high rate of tuberculosis among alcoholics.

The public health nurse occupies a crucial position in case-finding and health education. She can interpret the patient's condition to his family, and make referrals for other forms of community help.

Most alcoholics are usually ready to give up drunkenness, but are unable to visualize a life without drinking. The nurse can frequently lead to acceptance of help. The nursing profession can serve as a catalyst to stimulate others to accept full responsibility for this major public-health problem. —*Raymond G. McCarthy*, associate professor of health education, Center of Alcohol Studies, Yale University, New Haven, Conn.



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Employing Students

Raps Growing Practice of Paying Student Nurses for Added Services

The widespread and growing practice of employing student nurses in nursing services outside of their educational programs is a clear violation of the law and contrary to the public interest.

State nursing practice acts permit students to practice nursing under proper controls as part of accredited education programs, but clearly do not allow the practice of nursing by students for compensation.

State nursing boards must bear a large share of the responsibility for maintaining adherence to accepted standards of education within the various states. Nursing students in state-accredited programs have a right to expect that the boards will protect them from practices which are detrimental to their education and to their health and welfare. —*Mrs. Margaret F. Carroll, R.N.*, assistant executive secretary, American Nurses' Association, New York City.

Practical Nurses

Shortage of Practical Nurses Great, Speaker Says; Asks for Survey

The shortage of licensed practical nurses is still great as a result of continuing expansion in nursing-home and hospital facilities.

An over-all survey is urgently needed to determine the number of practical nurses required to give adequate, safe nursing care to all patients. A survey just released by the U.S. Office of Education and the National League for Nursing showed that 16,710 students were admitted to programs of practical nursing education in 1956-57. But this survey does not show the total need.

Teaching of practical nurses should be patient-centered at the bedside, rather than organized on the old pattern of three to four months of rigid curriculum. The student practical nurse under proper training should be qualified after one year to take an examination to become a licensed practical nurse.—*Mrs. Vera P. Hansel, R.N.*, chief, practical education, department of vocational education, Department of Health, Education, and Welfare, Washington, D.C.

American Psychiatric Association--

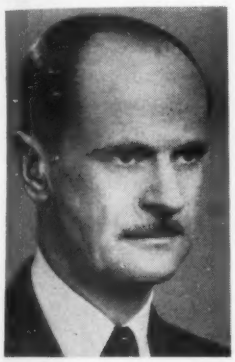
San Francisco, May 12-16

New Facilities

Large Mental Hospital Called Outmoded, Inadequately Staffed

The large mental hospital is antiquated, outmoded, and rapidly becoming obsolete. We still can build them, but we cannot staff them; therefore, we cannot make true hospitals of them.

After 114 years of effort, no state hospital has an adequate staff as measured against the minimum standards set by our association. Only 15 states have more than 50 percent of the total number of physicians needed to staff the public mental hospitals, according to these standards. On the national average, the number of registered nurses is calculated to be only 19.4 percent adequate; social workers, 36.4 percent, and psychologists, 65 percent. Even among the least highly trained personnel, the number of attendants is only 80 percent adequate.



Above, left: William O. Malamud, M.D., professor and chairman, department of psychiatry, Boston University School of Medicine, was named president-elect of the American Psychiatric Association at its 114th annual meeting. Dr. Malamud previously was secretary of the group. New president is Francis J. Gerty, M.D. (above, right), professor and head, department of psychiatry, University of Illinois College of Medicine, Chicago.

One must conclude that our mental hospitals today are bankrupt beyond remedy, and should be liquidated. It seems unlikely that there can be much improvement in the staffing of our institutions.

However, we are in a period of hopeful change in treatment facilities. These include: opening of psychiatric wards in general hospitals; increasing number of out-patient clinics; "day hospital" and "night hospital" facilities; half-way houses; extension services whereby the hospital provides care to patients living at home; liberalization of insurance plans to provide care for the mentally ill, allowing greater utilization of wards in general hospitals and private mental institutions; small intensive units, either as independent hospitals or as sections of larger hospitals; rehabilitation services and after-care clinics.

As the new facilities increase in number, readily recoverable patients can be treated and returned to their communities. The prospect remains grim for the less readily recoverable, however, unless new ways are found to meet their needs.

Facilities should be established for providing care and custody of chronically ill individuals for whom there is no clearcut medical or psychiatric treatment. Such facilities should be planned as a home or colony rather than a hospital, utilizing the knowledge of city planners, group social workers, educators, public health personnel, sociologists, and specially trained administrators.

We should differentiate between psychiatric treatment and "care and custody." Within this framework would be community-oriented intensive treatment facilities on one hand, and a new type of facilities for care of the long-term ill on the other. This mechanism would allow for the most effective utilization of highly trained personnel for treatment of the readily recoverable, and would create a new specialized group for rehabilitation and development of the maximum potential of individuals not capable of full recovery. —*Harry C. Solomon, M.D.*, superintendent, Massachusetts Mental Center, Boston; president, American Psychiatric Association.

Psychiatrists in Space

Effect of Isolation Studied As Prelude to Space Travel

Psychological stresses likely to be encountered in space flights are a major area of research in space medicine. Problems being investigated include isolation, confinement, changes in sensory input, and prolonged exposure to danger.

To understand effects of the stresses imposed in laboratory studies simulating space flights, subjects are evaluated before and after each experiment by a series of psychiatric interviews and psychological tests. These are supplemented by a group of physiological and biochemical measures.

Isolation studies in the laboratory have revealed consistent patterns of response to removal of external stimuli. In early stages of isolation, the subject's characteristic defenses appear to be exaggerated. Later, defenses become more primitive, and the subject often terminates the experiment. Schizoid subjects usually are first to reach the limit of tolerance.

Group confinement appears to overload subjects' mechanisms for handling a variety of interpersonal problems. Men who have maintained effective relationships with others in the past become puzzled by

(Continued on page 30)

World Health Assembly--

Minneapolis, May 28--June 13

Surgeon-General Burney Named President of World Assembly

The World Health Assembly, governing body of the World Health Organization, at its 11th annual meeting in Minneapolis, unanimously elected Leroy E. Burney, M.D., surgeon general of the U. S. Public Health Service, as its president.

The first session to be held in the U. S., this assembly commemorated the tenth anniversary of WHO. A special two-day meeting celebrating the anniversary preceded the assembly's three-week session which drew the largest attendance in WHO history. Representatives of all 85 active member states of WHO as well as observers from the United Nations, its specialized agencies, and 32 nongovernmental organizations attended the meeting.

A call for greater emphasis on health research was issued by the assembly. Announcement was made during the session of a special contribution by the United States of $300,000 to facilitate programs in this field.

The 1959 public health program adopted at the session includes nearly 800 projects, and emphasizes extension and intensification of the global malaria eradication program, increased smallpox control, and broadening of WHO programs in the fields of public health administration, nursing, maternal and child health, mental health, nutrition, and control of venereal disease. To finance these programs, the assembly adopted its largest budget to date, $14,287,600.

Other major decisions by the group included agreement on a comprehensive program to deal with the health implications of the peaceful use of atomic energy, and a recommendation for study in the new field of sports medicine. The proposal to investigate peaceful uses of atomic energy, made by the USSR and supported by the U.S. and 21 other countries, opens the way for WHO to help underdeveloped countries utilize radioactive isotopes in medicine, and to study the relationship of radiation to health.

A proposal that all WHO member countries take 2 percent of their annual military appropriations and contribute it to activities for expanding international technical assistance was made during the meeting by Thomas Parran, M.D., former U. S. PHS surgeon general. These funds, he said, should be in addition to regular contributions made to WHO and other groups and should be used to expand United Nations programs of technical assistance.

Dr. Parran made the proposal during his acceptance of the Leon Bernard Foundation Prize, presented to him by the assembly for his outstanding contributions to the development of public health services in the U.S., particularly in the expansion of national control programs for venereal disease, tuberculosis, and cancer. Dr. Parran is the eighth recipient of the prize which perpetuates the memory of a French scientist by recognizing outstanding achievements in the field of social medicine.

The assembly selected Brazil, France, Guatemala, Iran, the Soviet Union, and Vietnam to name representatives for three year terms on WHO's 18-member executive board. The U.S. is also represented on the board.

Named as vice-presidents of the assembly were: Dr. J. Anouti, director-general, Ministry of Public Health, Lebanon; Dr. A. Sauter, director of public health, Switzerland; and Dr. Tran Vy, health minister, Vietnam. Director-general of WHO is Dr. M. G. Candau of Brazil. The assembly will meet next year in the WHO headquarters city, Geneva, Switzerland.

Student lady health visitor weighs baby at Goodcliffe Mother and Child Health Centre near Rangoon, Burma, one of chain set up by the Burmese government throughout the country with advice and assistance of WHO. Burmese government and WHO organized country's first center for mother and child health in 1951. WHO has also aided Burmese program by helping train nurses, lady health visitors, and midwives, and doctors in pediatrics and child care.

Long-Term Care Unit:

24 Successful Years

By E. Hampton Decker*

• Since 1934 the Springfield Hospital has had a long-term care unit. Being with a hospital which has such a unit after being with others which have not, I am convinced that the benefits far outweigh the disadvantages. I recommend a long-term care unit for the consideration of any general hospital which wants to do a total job for the community.

The Springfield Hospital currently has 373 beds, 51 of which are for long-term care. The greater Springfield area has a population of somewhat over 260,000 people and has five hospitals for acute care, one being purely obstetrical and one having only 35 beds. In addition, the City of Springfield has recently built the municipal hospital, which has 481 beds and is planned to reach eventually a capacity of 659 beds, solely for long-term or chronic care, including some domiciliary care.

When our present hospital building was completed in 1933, on pledges made in 1929, finances were a problem. Occupancy was also low. So in 1934, with the cooperation of the Department of Public Welfare of the City of Springfield, a 34-bed chronic-disease unit was opened. At that time these and the beds in nursing homes were the only long-term beds in the community. After a short time the unit was enlarged to 51 beds.

For many years admissions were limited to recipients of aid from the Department of Public Welfare of the City of Springfield. About four years ago, however, changing times, changing needs, and a bequest under the will of Charles and Edith Van Norman caused a change in policy. We now admit patients who pay their own charges as well as those from the welfare department.

Our present procedure is to give preference to any private-paying or so-called Van Norman patient to fill a vacancy before making it available to the welfare department. However, only about 20 percent of our long-term patients are now paying the hospital directly.

In spite of the new Municipal Hospital, there is no expectation that the City of Springfield will not want to continue its relationship with our hospital.

In our hospital a ward patient is a patient who does not have his own private physician, and who receives medical care from the medical staff of the hospital without charge. Since we have no unit in the hospital greater than four beds, on some floors semiprivate patients occupy the areas used on other floors for ward patients.

The 51-bed long-term care unit consists almost entirely of four-bed units with only four private rooms, all of which are more on the order of "quiet" rooms. When we began to take private-paying patients, a differential in the rate charge was made between ward, private, and semiprivate. We now charge $8 for ward and semiprivate, and $9.50 for private care. The $8 represents a little less than current estimated cost. Costs here seem to approximate about one-third of the daily cost of caring for an acute patient, according to our methods of accounting, which involve using the Massachusetts state reimbursement forms.

In 1957 our average cost per day for this unit for routine care was $7.66; for all-inclusive care it was $7.94. Our present welfare reimbursement rate on this unit for all-inclusive care is $7.38. Our average all-inclusive cost on our acute wards in 1957 was $22.16. Our present all-inclusive reimbursement is $18.59.

This differential in cost comes from some very obvious differences between acute and long-term care. First, there is a very slow turnover in the long-term unit, which averages approximately 50 admissions per year or about one per bed, but may be as high as 90 one year and as low as 17 another. Second, ancillary services used are very much less per patient day than in the acute units. Third, while nursing care is on a high level, the ratio of auxiliary personnel to nurses is higher than on the acute units, and the ratio of total personnel to patients is lower.

One last factor is that occupancy over the years has been close to 98 percent, with the result that total cost is divided by about a maximum number of patient days. The two percent by which occupancy is under 100 percent is caused by the one or two vacancies which exist only long enough to find the proper person to admit.

A master's thesis written in 1951 for Yale University by Robert F. Tuveson, about long-term care units

(Continued on next page)

*Administrator, The Springfield (Mass.) Hospital.

in general hospitals and specifically referring to our unit, contained the statement, "Convalescent and custodial patients should be cared for in a nursing home." We agree with this sentiment, and yet it is very difficult to limit admissions to rehabilitative patients when long-term care bed needs are so great. The Lemuel Shattuck Hospital is finding this approach difficult. Add to this the difficulty of uprooting people who have been in this unit for a long enough time to consider it their home, and you can understand the problem, even if a nursing home or the Municipal Hospital can suit their needs.

We have taken pride in the people we have rehabilitated. Since approximately 20 percent of our discharged patients have gone to private homes, we assume that these have been aided and improved while in our care. However, to a considerable degree, we have not been sufficiently aggressive in rehabilitation. We would like to be more active in it and are currently seeking a mechanism for screening patients from the welfare department and from direct referrals to assure us of patients most likely to be improved with the use of the general hospital's facilities available to us.

Of course, as soon as we increase our rehabilitation efforts, "old devil cost" will come into play. In simple language, as we step up rehabilitation, the community will gain and the hospital will lose.

The problems which have beset us in the operation of our unit are very similar to those which are current in the whole field of long-term care. It seems to be most satisfying to most individuals to see spectacular results for their work and efforts. Doctors and nurses being human, it is natural for most of them to get their satisfaction in the unit with fast turnover—with patients who are acutely ill, and quickly better—rather than in a long-term care unit with its lack of urgency and spectacular results.

These problems therefore have been keyed directly to this lack of urgency. In the beginning a rotation system was attempted in the head nurse position, but eventually the job settled upon our present person, who does a splendid job and takes great interest and pride in her work.

Nursing care certainly is one of the most, if not the most, essential ingredient in long-term care. The wonder drugs and services of the specialists are not nearly so important in a long-term unit as a nurse who can expertly apply her knowledge of nursing fundamentals. We are fortunate, for instance, that the personnel on this floor consider bed sores as things patients come in with but do not have for very long.

To combat the problem of proper staffing, a policy was finally set that people working on this unit would receive a bonus of 10 cents an hour more than those doing identical jobs on the acute units. This policy seems to have overcome, or at least lessened, our personnel problems on this floor.

Day-to-day medical care has been a problem for a considerable time. For many years, the responsibility of routine medical care on this unit was not accepted as a direct responsibility of the medical staff, so that various doctors were placed in charge by the administrator and stayed for as long as they could be kept at it. However, probably because of the perpetuity of the job, eventually a new person had to be found to do it.

While, theoretically, geriatric problems are constantly being met in private practice and, therefore, the unit should present an opportunity for learning to the practitioner and to the intern or resident, geriatrics has not been found to be an area which interests either the house staff or the medical staff. Occasionally a house officer has been found who has taken an interest, and I am sure he has received more than he has given, but he has been the exception rather than the rule.

About two years ago the department of medicine of our medical staff accepted the full responsibility for providing the medical care and has assigned two physicians to alternate on a six months' basis, with a senior medical resident doing some of the essential coordinating. I believe this system is providing a far more satisfactory arrangement than heretofore, when one individual had to carry all but the specialized work by himself.

In fairness to our medical staff, there has never been a problem of any special care or treatment being available immediately. For many years the chiefs of surgery and medicine made rounds in the unit monthly and assigned men to any special problem immediately upon

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request. Current medical coverage is sufficiently good as to eliminate the need. Better medical care is one of the fundamental benefits of having such a long-term unit connected with a general hospital. Perhaps we who are close to it do not fully realize the total value of this to the patient.

Four or five years ago over 51 long-term beds represented approximately 20 percent of our total bed capacity. At the same time the acute patients were waiting from six to eight weeks for admission to this hospital for elective surgery. With a shortage of acute beds within the community and within the hospital, there was considerable pressure from the medical staff, and with some justice, to abandon this long-term care —to let it be done by others, and to utilize beds in this general hospital for the care of acute patients. A powerful argument was that about 2,000 acutely ill patients could be cared for in the 51 beds involved each year, compared with 100 long-term patients.

Since we have opened 111 acute beds in the last four or five years and have just begun to build a wing of another 183 beds (including a 34-bed psychiatric unit), this pressure to eliminate the chronic care unit seems to have disappeared.

Because our unit was exclusively used by the Department of Public Welfare for many years, we have suffered, we believe, from the connotation that this is a charity arrangement. It is only now, after approximately five or six years of accepting private-paying patients, that we are losing some of this so-called stigma of "public welfare." I am not sure that we will ever fully lose it. Also, our concentration on four-bed rooms rather than on private and two-bed rooms, which are commonly emphasized in nursing homes, may not make us as acceptable to families able to pay fully for care.

It seems probable that some of the interest of hospitals in having chronic care or long-term care units connected with their hospitals can be traced to the number of long-term cases they are forced to carry on their acute units because of lack of any reasonable facilities to which to transfer them. A long-term care unit does help solve that problem, because about half of our admissions to this unit seem to be from our acute wards. However, we currently have a considerable group on our own acute wards waiting for transfer. The same situation exists in other hospitals.

Therefore, even though we have such a unit available, we still have the problem of elderly people needing no specific hospital treatment taking up acute beds. This condition comes and goes in our hospital, while in others it may be more permanent. But vacancies cannot be created when you want them, and since we operate our long-term unit at virtually 100 per cent occupancy we must wait for a discharge, a transfer, or a death to allow room for a new person.

I presume that if or when we always have a room to which to transfer a patient, it will indicate that our occupancy rate is down, and lower occupancy will probably raise the cost per patient day. A long-term care unit therefore does not offer a cure for the occupancy of acute beds by long-term patients, but it does help.

Another rather peculiar thing we have found as the unit improves its attractiveness as a suitable place for the care of the private-paying patient is that when patients are placed on the waiting list for transfer, families request a reduction from the rates charged on the acute units. This action may indicate an unwillingness to spend as much for chronic-disease care or may merely mean the families are frightened by the fact they can see no end to the expense.

These seem to be the major problems we have encountered. In reviewing them with our nursing supervisor, she said that other problems are that occasionally some of the senile patients tend to be quite noisy to be connected with a general unit and that the disorientation some go through can also be disconcerting. However, she is very sure that the good in having such a unit as part of a general hospital far outweighs the bad.

I believe an over-all problem, in addition to the specific ones stated, is being sure that the area does not become, medically and nursing-wise, a forgotten area.

If it is part of a hospital's job to provide services to the sick, the chronically ill can certainly be cared for with no real change in concept. The benefits accruing to the community, the patient, and the hospital from adding a long-term illness section to a reasonable-sized general hospital are:

1. The quality of day-to-day care is very likely to equal that of the care in the acute units, which is probably the best in the community.

2. The resources of the general hospital, which are usually the best in the community, are available to this group of patients without costly duplication.

3. Since these ancillary services are not needed too often and since nursing care can be provided on the same basis as in completely separate, large, chronic-care institutions and nursing homes, costs are kept down.

4. With the proper concepts maximum rehabilitation should take place as well in a unit of a general hospital as in a purely long-term hospital, and better than in the average nursing home.

5. It does provide an opportunity to transfer long-term patients from acute facilities, although this cannot be done instantaneously, at least in our case.

6. The public is even more conscious of the patients on this unit than of those in the acute units, now that acute stays are so short; so, as a measure of public relations, the interest taken by such organizations as Rotary Club, American Red Cross, Links of the Golden Chain, church groups, garden clubs and others, as well as individuals, has some value to the total hospital.

AMERICAN PSYCHIATRIC

(Continued from page 25)

the intensity of their reactions to apparently trivial incidents. Regression is common.

Rapid reintegration occurs at the end of the experiment and produces a clinical impression that the experiment has served as a "therapeutic" experience. —*George E. Ruff*, Captain, USAF (MC), chief; and *Edwin Z. Levy*, Captain, USAF (MC), research psychiatrist, Stress and Fatigue Section, Aero Medical Laboratory, Wright-Patterson Air Force Base, Ohio.

Psychiatric Units

Trained Personnel, Education Needed To Install General Hospital Unit

Installation of a psychiatric unit and its maintenance in a general hospital are not difficult if trained personnel are available and if the hospital staff and administration are well-informed regarding the community need for such a treatment unit.

Physical layout and equipment differ little from that in a medical or surgical unit, except for a few safety precautions such as protected windows and doors, and for seclusion rooms, larger day rooms, occupational and recreational areas, specially equipped nurses' stations, and private interview rooms, preferably in a wing not separate from the main hospital.

The main problem is to overcome prejudice, fear, and misunderstanding about mental patients in both the hospital and the local community. Other pitfalls to avoid are the desire to start with too small and uneconomic a unit, and a lack of specially trained personnel. A unit of at least 20 beds, headed by an experienced psychiatrist able to integrate the unit into the rest of the hospital, and staffed with competent personnel, can operate successfully in any area of about 100,000 population.

Problems concerning economic operation, selection of patients, and admission procedures should be solved by a joint committee of psychiatric and hospital administrative staff. This committee should devise rules for operation of the unit.

General hospital psychiatry offers great hope for treating mental patients early and preventing chronicity. A survey of sample representative psychiatric units throughout the country reveals successful operation with very few exceptions, a growing trend toward installation of these units, and enthusiasm about the benefits obtained. —*A. E. Bennett, M.D.*, chief of psychiatry, Herrick Memorial Hospital, and associate clinical professor of psychiatry, University of California, Berkeley, Calif.

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The World and Medical Care—Part III:

Health Care in Northern Europe

By John G. Steinle

EDITOR'S NOTE: This is the third of a series of articles by John G. Steinle, consulting editor of HOSPITAL TOPICS, on medical care abroad. Because of discussion recently in the United States regarding the government-supervised voluntary health insurance programs in Denmark, this subject receives emphasis.

Germany. Health insurance in Germany is not unlike that of other European countries having compulsory health insurance covering the entire population. In effect, deductions are made from the workers' pay and placed in a national fund. The government pays into the fund for the aged, widows, and unemployed.

Each year a family may select its physician. Selection is subject to some limitations. For example, a physician may not have more than a maximum quota of patients. The physician is compensated from the fund according to a formula which takes into consideration the number of office visits, home visits, and the total number of patients who have designated him as their physician. Once selected, he serves the family for a year.

In most cases the "family doctors" do not have hospital appointments. The medical staffs of the German hospitals are predominantly the faculties of the medical schools. The hospitals are for the most part operated by the government with substantial autonomy vested in the staff-faculty of each hospital.

On the whole, German hospitals are clean and appear to be well operated. The public, the press, and the medical profession in Germany generally are well satisfied with their health programs. While the majority of German hospitals are in old buildings, the equipment is usually very modern. Laundry and dietary equipment is particularly efficient, durable, and simple to operate.

The German nurses do not receive nearly as much technical training as do those in the United States. Their work is more menial in nature, and their discipline is exceedingly strict. One gets the impression that they are in constant fear of the medical staff. They stand in obvious awe of the "professor"—the equivalent of our chief of service.

While some interesting experimentation is being done in the care of the mentally ill, Germany has not made as many advances as Holland, Belgium, and the Scandinavian countries in this field. Most mental patients are cared for in large institutions, similar to those in the United States.

One criticism German medical authorities often make of their system concerns the lack of continuity of patient care. For example, when a patient is sent to a hospital he loses all contact with his family physician. Similarly, when he is returned from the hospital, the specialists lose all contact with him.

Many German experts believe that it would be highly desirable if a system could be developed which would provide the specialist in the hospital with the patient's medical background as known by the family physician and, conversely, the family physician with the details of the patient's hospital experience. These authorities express the opinion that one of the most important elements of the American system is continuity of care.

Belgium and The Netherlands. While differing in detail from Germany's compulsory health insurance plan, the Belgian and Dutch systems are substantially similar. The first compulsory health-insurance law was passed in Germany in 1883. Prior to the war Belgium maintained a voluntary system subsidized by the government.

The hospitals in Holland are fairly well equipped. They are clean, and the patient rooms are large and "airy." About a third of the hospitals are new. Most of the others have been remodeled since the war (following their requisition by the German military).

The hospitals in Belgium are generally older and not as clean as the German and Dutch hospitals. Recently, a program has been started for refurbishing, remodeling, and re-equipment of the hospitals which are predominantly government-operated.

Of particular interest in the hospital field are the progressive programs for mental health. The directors of the mental health program in The Netherlands made a strong point of the distinction between the "social psychiatric programs" and the "institutional or hospital program."

Admittedly, there has been a concentration of effort in the "social" or preventive aspects, which include:

Concussion teams. Any person in Amsterdam who suffers a concussion or other brain trauma is immediately examined by psychiatrists and neurologists who work in mobile teams.

Posthospital clubs. Clubrooms are operated for mental patients discharged from hospitals. Hospital psychiatrists and others are available for consultation.

Foster homes. Persons are placed in carefully selected foster homes in lieu of hospitalization or after hospitalization.

Day programs. Special facilities are provided for mentally ill persons for care during the day. These facilities have recreational and occupational therapy, diagnostic rooms, and occasionally rooms for administration of shock.

(Continued on page 33)

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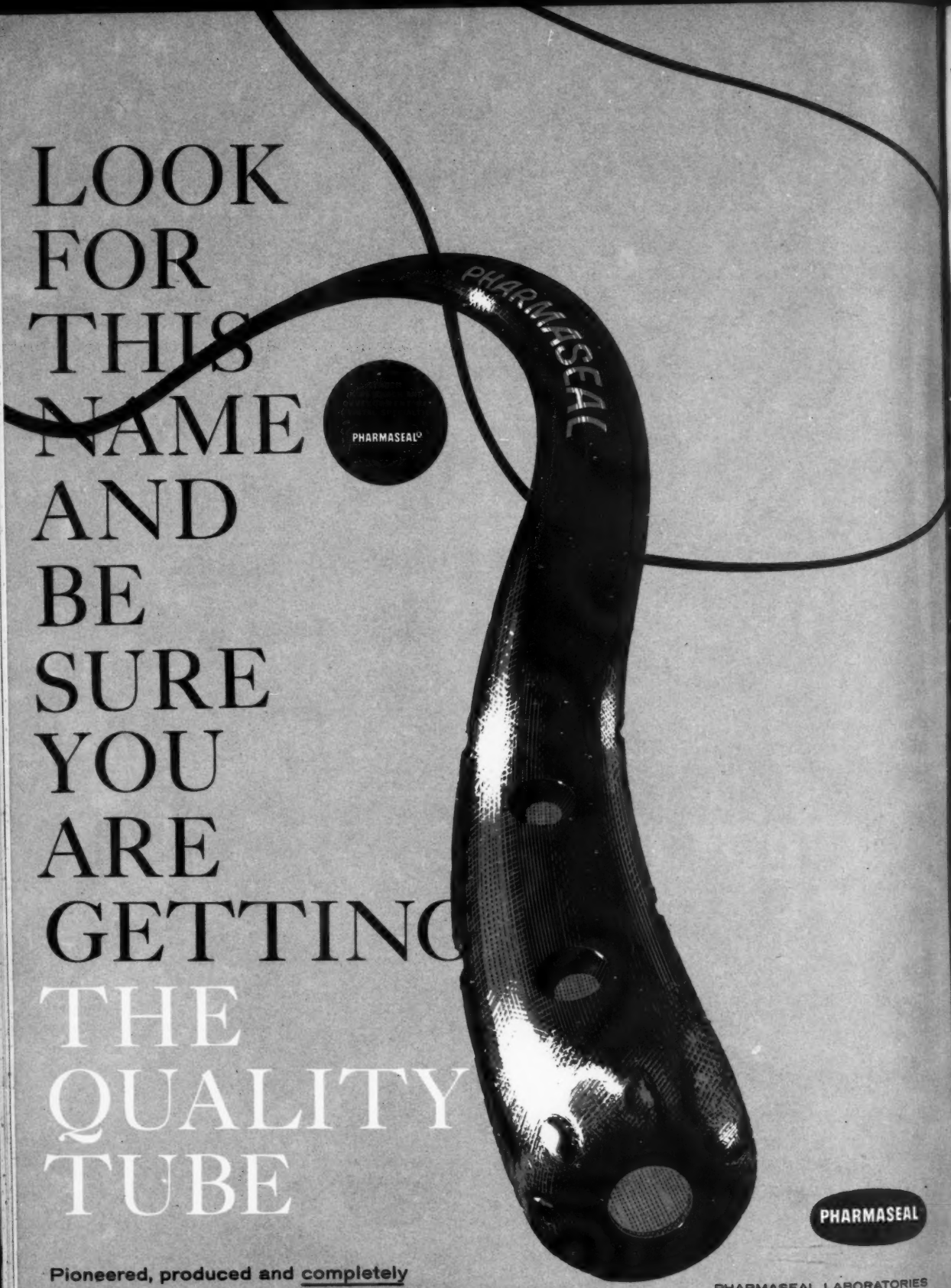

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(Continued from page 32)

Night hostels. Similar to the day facilities are special hostels in which the mentally ill can stay at night and receive some therapy while they perform their regular tasks during the day.

Group living. Selected patients are permitted to live in the community, in apartments or homes, often together, with a minimum of therapy and supervision.

The school psychiatric programs in these two small countries are extensive according to our standards.

Much of the progressiveness in mental health in these countries is attributed to the experiences during World War II, when entire mental hospitals had to be vacated on 24-hour notice for conversion to barracks or other German military uses. From these experiences it was determined that the mentally ill usually recovered much faster or deteriorated less rapidly when in noninstitutional buildings. In both countries there are still large mental hospitals of the type traditional in the United States, but the number of persons per thousand population hospitalized in these facilities is about one third of that per thousand population hospitalized in similar institutions in the United States.

Denmark. The health insurance programs in Denmark began as private "sick clubs." The programs are still voluntary, but closely supervised and often subsidized by the government. As early as 1892, legislation provided for state grants to health insurance funds. In return, the funds had to submit to state supervision and grant as a minimum the benefits required by law.

There are nearly 1,600 health-insurance funds. Active memberships in them are limited to persons of small means. Persons whose income or capital exceeds this limit may join as "continuation members." While not providing the full benefits of active membership, continuation membership permits transfer to active membership in case of a change in income, and also certain other benefits.

The National Insurance Act of 1933, which formed part of the so-called "Social Reform Acts," codified the acts on sickness and invalidity insurance and made the right to old-age pension, which since its introduction had been a noncontributory benefit, dependent on membership in a health insurance fund or health insurance society.

In order that persons who were not insured against sickness as active members of a health-insurance fund or society might also qualify for invalidity and old-age pensions, the National Insurance Act made it compulsory for all Danish nationals between the ages of 21 and 60 who were not already members of a health-insurance fund or society, and whose health was such as to make them eligible for insurance, to apply for admission as passive members of a fund or society.

Usually the health funds maintain a list of doctors. Each year the members select a family physician from this list. Specialists are also paid by the health funds as required.

The right to receive benefit from the fund at all is subject to the completion of a qualifying period. For first admission, the period is six weeks; for transfer from passive to active membership, six months; for confinement benefit, 10 months.

If a member has received a total of 420 daily benefits from the fund in the course of three consecutive financial years, his right to additional benefits is suspended. In addition to this general rule, the duration of cash benefits is subject to certain special rules. The benefits prescribed by law include:

1. *Free medical care*—by a general practitioner, granted on the basis of an agreement between the confederations of the health insurance funds within a large area (such as Copenhagen) and the organization of the medical practitioners covering the same area. These agreements, which are approved by the Minister of Social Affairs, provide, as a rule, for two forms of remuneration to be paid to the general practitioners by the funds—either a fixed annual remuneration per member registered as a patient with the general practitioner concerned, or a fee per consultation.

The former type of remuneration is generally applied in the towns; the latter, in the rural areas. To the fixed remuneration, however, are added special supplements for medical care in certain cases—for example, on Sundays, holidays, and during the night.

2. *Hospitalization.* The majority of hospitals are district hospitals, owned and operated by the local governments. The rates, approved by the central government, are usually only half of the operating cost. The health insurance funds pay a rate substantially lower than the published rates. For example, in Copenhagen the cost of operating the local hospitals averages 60 kroner (about $8.40). The published rates are 4 kroner. The health insurance funds pay only 2 kroner. The rates in provincial hospitals are substantially higher—8 to 10 kroner—and the funds pay approximately half of the published rates.

3. *Daily cash benefits.* To be eligible for cash benefits, the member must have suffered a loss of income as a consequence of his illness, and the amount payable to him may not exceed four-fifths of the lost earnings.

4. *Medicine.* The members receive from the health insurance funds three-fourths of their outlay for insulin, liver preparations, and other vital medical preparations. This expenditure is refunded to the health insurance funds by the state.

5. *Funeral benefit.* In the case of death of a member, a funeral benefit of about 450 kroner (about $65.25) is paid.

In addition to the above required benefits, many funds provide for dental care, maintenance in approved convalescent homes, home nursing, physiotherapy treatments, and the cost of spectacles, surgical appliances, and prostheses.

Seventy percent of the total amount of income of the funds is from contributions of active members. The average contribution, including that for daily cash benefits, amounts to about 100 kroner per member (about $14.50).

(Continued on page 35)

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1 attain the highest degree of cleanliness ever achieved,

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WORLD AND MEDICAL CARE

(Continued from page 33)

Passive members pay an annual contribution of 3 kroner. In addition, like the active members, they pay a special contribution to the invalidity insurance—about 10 kroner a year.

State subsidy is about 20 percent of the total income of health insurance funds. In addition, a special state (and municipal) subsidy is granted toward the excess expenditure for chronically sick members.

The state meets the full expenditure of the funds on vital medical preparations, and the local authorities meet the full expenditure of daily cash benefits in the case of confinement of women factory workers.

No new hospitals have been built in Denmark since World War I. Many of the buildings have been remodeled. The hospitals are clean and appear to be efficiently operated within their physical limitations. Ninety percent of all beds are operated by government subdivisions, usually municipalities or counties. The hospitals are usually multi-building affairs that require continuous communications between buildings. Kitchens are efficient but with much less equipment than in the United States. The Copenhagen hospital bill of fare is an epicure's delight—especially the midafternoon smörgasbord.

Surgeries have modern equipment. Obstetrical units are very small, because most births occur at home. Formula rooms are unheard-of, since all mothers breast-feed their children.

In 1952-53 one of the world's worst polio outbreaks occurred in Denmark. After this epidemic a seaside hotel was converted to a physiotherapy and rehabilitation center for postpolio patients. The technics and equipment in this institution are quite advanced.

The mental hospitals are institutional in nature and are remote from population centers. This has created many staffing problems. There is an extensive mental health prophylactic program for children.

The child and maternal health programs are quite extensive. Every family with a child under one year of age is visited at least every two months by a public health nurse. During the first four months infant and mother are visited every two weeks.

The tuberculosis hospitals are being closed or converted to other use.

The medical profession is organized much as it is in the United States. The physicians have much the same autonomy in hospitals. The local medical societies enter into agreement with the local health-insurance groups. In all of Europe, Denmark has the medical-care system which most closely resembles that of the United States. There is, however, a special commission that is studying the entire problem of medical care. The establishment of this commission was opposed by organized medicine.

EDITOR'S NOTE: Next month's article will be a full discussion of the National Health Service of Great Britain. The Ministry of Health has prepared answers to a series of questions put to it by Mr. Steinle, who said to the Minister of Health, "Admittedly these questions are leading and loaded."

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Regional Differences in U. S. Hospitals

By Louis Block, Dr. P.H.

*Births**

Seventh in a series

• There are regional differences in the numbers and kinds of hospital facilities and services available, and in their utilization. The role of the regional hospital can best be portrayed by studying it as a part of the total United States picture, and as an entity in itself.

The largest number of births in:

1. All hospitals are in the East North Central region.

2. Short-term general hospitals are in the East North Central region.

3. Nonprofit short-term general hospitals are in the East North Central region.

4. Proprietary short-term general hospitals are in the West South Central region.

5. Governmental (excluding Federal) short-term general hospitals are in the East North Central region.

Practically all births are in short-term general hospitals. Most of these are in nonprofit controlled hospitals in all regions. There is a higher proportionate share of births in the proprietary controlled hospitals in the West South Central and East South Central regions than in other regions; and a higher proportionate share of births in governmental (excluding federal) controlled hospitals in the South Atlantic and West South Central regions than in other regions.

*Based on the 1956 Administrators' Guide Issue, *Hospitals*, Journal of the American Hospital Association.

1. The Region as a Part of the United States

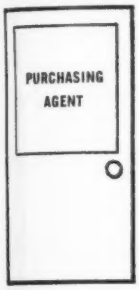
Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific	Total
Total	6.1	19.3	13.7	22.0	6.0	9.1	9.4	4.2	10.2	100.0
Short-Term General	6.2	19.9	12.9	22.9	5.9	9.3	9.1	4.0	9.8	100.0
Nonprofit Short-Term General	7.6	22.6	10.7	25.0	4.3	9.9	6.2	4.1	9.6	100.0
Proprietary Short-Term General	1.4	15.5	19.1	3.4	12.2	5.2	26.7	1.9	14.6	100.0
Gov'tal (Excl. Federal) Short-Term General	2.3	10.4	19.5	20.5	10.6	8.3	14.9	4.5	9.0	100.0

2. The Region as an Entity in Itself

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
Short-Term General	96.5	98.2	89.4	98.2	94.7	97.5	92.6	89.9	91.6
Nonprofit Short-Term General	88.4	83.8	55.9	80.9	51.2	77.9	47.5	68.5	67.4
Proprietary Short-Term General	1.4	4.8	8.3	0.9	12.1	3.4	16.9	2.6	8.5
Gov'tal (Excl. Federal) Short-Term General	6.7	9.6	25.2	16.4	31.4	16.2	28.2	18.8	15.7
Other	3.5	1.8	10.6	1.8	5.3	2.5	7.4	10.1	8.4
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

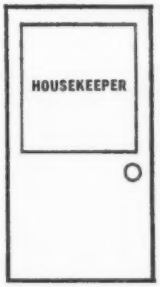
Sufficient detergency to satisfy the Housekeeper, efficient disinfection to satisfy the Professional Staff, lighter labor costs to satisfy the Administrator, and minimum costs of best supplies to satisfy you - Tergisyl offers all.

For every 100,000 square feet of floor space in your hospital now cleaned and then disinfected by man-and-mop-and-pail, you can save as much as 7½ man days per week, or 60 man hours, by adopting the one-step Tergisyl method.



Better control of cross infection through simplified procedures is possible with the one-step Tergisyl method of disinfecting and cleaning. Reservoirs of staph, other common pathogens, and TB bacilli are destroyed routinely, efficiently with less effort.

Complete twice the work in half the time – and save money on both labor and materials. One-step Tergisyl cleaning procedure – which includes dependable disinfection – is quickly accepted, easier to follow.



Lehn & Fink's new weapon to combat cross infection

Tergisyl T.M.

DETERGENT–DISINFECTANT

Best defense against spread of staph is careful attention to total environmental asepsis, including floors. With the Tergisyl method, efficient general disinfection is simultaneous with routine cleaning.

Cuts labor cost 47%

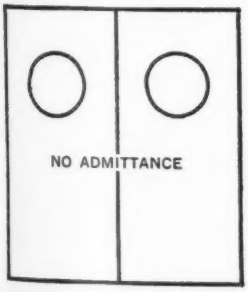
(by mop-and-pail method)

Cuts labor cost 22%

(by machine scrubbing-vacuum method)

Cuts material cost 5% to 10%

(using either of above cleaning-disinfecting methods)

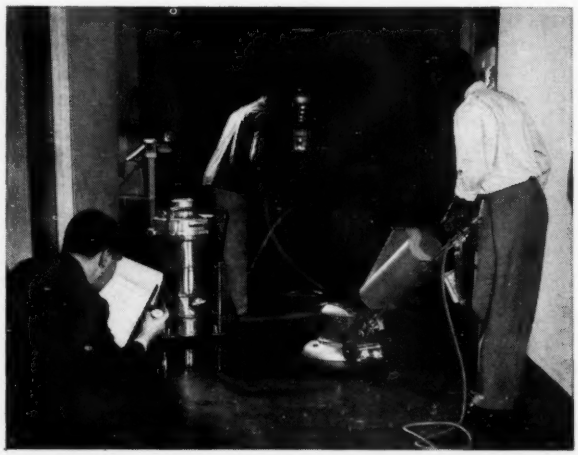


Keeping the O.R. "clean" in every sense of the word is easier, quicker with the new Tergisyl technic. Efficient disinfection and dependable detergency are combined in one cleaning step to achieve environmental asepsis you can be proud of. Has no effect on conductivity.

For details of comparative time studies under actual hospital conditions—

TURN PAGE

Comparative time studies of Tergisyl vs. conventional method washing and disinfecting using mop-and-pail technics. One-step Tergisyl method reduced the man-time required by 47%. Actual time saved was approximately 25 minutes per 1,000 square feet of floor area—a labor saving of 125 man hours or 15 man days per week in a 300-bed hospital.



Comparative time studies of Tergisyl vs. conventional machine scrubbing vacuum pickup, and mop-and-pail application of disinfectant. One-step Tergisyl method reduced the man-time required by 22%. Actual time saved was approximately 23 minutes per 1,000 square feet of floor area—a labor saving of 20 man hours or 2½ man days each week in areas of heavy soil in a 300-bed hospital.

Comparative cleaning and disinfecting efficiency of Tergisyl vs. conventional method. Subsequent inspection showed greater cleaning ability for Tergisyl than the detergent previously judged acceptable by the hospital. "Before" and "after" bacteriological tests confirm germicidal efficiency of Tergisyl.

Three years of research backed by over sixty years of experience have produced Tergisyl , detergent-disinfectant

Since control of cross infection, especially from Staph, has become a major problem for hospitals, Lehn & Fink has felt an increasing responsibility to do everything possible to aid in this fight. Producing the most efficient disinfectants for hospital use has been our chief concern for many years. In addition, we have tried to supply these disinfectants in as practical and easy-to-use a form as possible so that the hospital could devote its attention to actual medical and surgical care of the patient.

Seriousness of the Staph problem has now made more adequate and dependable disinfection a necessary part of patient care. Development of Tergisyl, combining the comprehensive bactericidal, fungicidal, tuberculocidal efficiency you have come to expect of our products with sufficient detergency to clean even heavy soil satisfactorily, took many years of research. An independent research organization has confirmed our findings under actual hospital conditions.* But the most convincing test of Tergisyl's labor-saving advantages is use in your own hospital. We hope you will try it. Why not write immediately for your free sample and literature?

*Details of report available on request.

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Plant Operation and Maintenance

Another in a series on hospital organization, based on lectures given at meetings of the Association of Western Hospitals and allied state groups

By John H. Gorby*

II. Utilities

• Utility services represent about one-third of the original cost of the hospital plant, and a major share of plant operating and maintenance costs. The design and selection of equipment and materials for the utility services warrant special consideration, therefore, so that the first cost may be reduced, repairs minimized, and the cost of labor, fuel, and electric power held to a minimum. At the same time, utility services must be adequate to protect the health and safety of patients, and to maintain proper conditions in the hospital plant. These two aims usually can best be accomplished by simplifying design, by using systems proved by experience, and by utilizing quality equipment and materials.

HEATING AND STEAM SUPPLY

In a hospital, a heating plant is required which is adequate to supply high pressure steam for the laundry, kitchen, and central sterile supply, and either low pressure steam or hot water for heat. In general, forced hot water can be said to provide a more constant temperature than steam, with less noise and lower operating and maintenance cost. However, because high pressure steam is also required, many hospital plants generate high pressure steam and use a heat exchanger to produce hot water for heating purposes.

Load Balance

As a rule of thumb, one boiler horsepower of capacity is required for each hospital bed to satisfy heating, laundry, dietary, and sterilizer requirements. Heating represents approximately two-thirds of the total load. Because of the ever-present possibility of a plant shut down, spare capacity usually must be provided for stand-by purposes. Care should always be taken to avoid operating any boiler unit at less than one-third capacity, since operating efficiency drops off sharply below a one-third load.

The following example may help illustrate proper load balancing. In a 100-bed hospital, two 100-horse power boilers were installed. Either could carry the normal full load. The second boiler was available for stand-by use and operation during overhaul periods. In this system, 100 percent over-capacity was provided. Operation below one-third capacity would be necessary much of the time during the summer.

A better system would be to provide one 70-horsepower hot water boiler, and two 40-horsepower high pressure steam boilers, equipped with a heat exchanger. Normally, the hot water boiler would carry the heating load, but the steam boilers, through the heat exchanger, could also supply hot water. Since the hot water boiler could be shut down each summer, there would be little likelihood of needing stand-by equipment for an overhaul period. Rarely would operation below one-third capacity be required. Only 40 percent over-capacity would be provided, resulting in substantial savings.

One 70-horsepower and two 40-horsepower high pressure steam units (or three 50-horsepower units of that type) could also be used and would give complete standby power for all services. The only extra cost involved is the difference in cost of the 70-horsepower units.

Fuel Selection

Oil or gas-fired boilers always should be used, unless the cost per B.T.U. exceeds the combined cost per B.T.U. of coal and its attendant handling costs. Both gas and oil eliminate the noise and dirt associated with coal and its resulting ash. If coal is used, because of lower costs, automatic stokers should be installed.

Heating Economies

Since building heat represents two-thirds of the load on the steam plant, it is wise to take advantage of all possible economies. A few methods of effecting fuel cost savings follow:

Establish written operating procedures.
Measure steam to determine where it is going and to ascertain losses.
Inspect all lines, traps, and insulation for leaks.
Check for over-heated spaces.
Eliminate unnecessary ventilation.

(Continued on next page)

*Director of Research, Project W-34, U. S. Public Health Service, San Diego, Calif.

(Continued from page 39)

Operate at the lowest possible pressures, to minimize heat losses.

Use automatic heat controls.

Zone areas for temperature needs.

Adjust heat according to outside temperatures.

Reduce peak boiler loads by rescheduling.

Insulate walls, roof, and windows.

Reclaim exhaust heat where possible.

Shut off unused steam lines.

ELECTRIC POWER

Very frequently, particularly in large cities such as New York, hospitals generate their own electric power. Rarely, however, are adequate records maintained to determine the relative merits of generating or purchasing power. Experience indicates that conditions must be extremely favorable if a small plant is to generate power cheaper than it can purchase that power.

In any case, the costs involved in generating power should be examined carefully to determine the proper course of action. Capital costs, insurance, and steam plant costs, properly chargeable to electric generation, must be all included in the analysis.

If amortization costs for replacing obsolete equipment are included, it is usually found that the cost of generated power is out of line as compared to the cost of purchased power.

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Service lines for purchased power should be brought in underground, when possible, to minimize the likelihood of interruptions. Whenever feasible two services from independent generating plants should be used, one for normal service, and one for emergency service. The two services should be interconnected by automatic throw-over equipment.

If separate services are not available, automatic-starting gasoline or diesel stand-by generators should be installed. As a minimum, emergency electric power service should have adequate capacity to supply operating and delivery rooms, stairways, exit lights, a few corridor lights, one elevator, steam plant auxiliaries, and a few strategically located outlets. These outlets should be equipped with small lights for identification.

Since x-ray and electroencephalography equipment is extremely sensitive to voltage changes, this equipment should be supplied through separate feeders and transformers.

AIR CONDITIONING

In this day and age, air conditioning is a prerequisite of a modern hospital. When properly designed, an air-conditioning plant has many advantages, although its primary purpose and chief advantage is maintenance of comfort through temperature and humidity control.

Among the other advantages of air conditioning, reduced housekeeping costs stand out. Air-conditioning filters eliminate much of the usual dirt and soot, thus increasing paint life, maintaining higher levels of illumination, and minimizing cleaning in general. Another major advantage is the increased working efficiency of the hospital staff. Morale is improved, and absenteeism from sickness is reduced.

The air-conditioning plant, again when properly designed, can improve steam plant efficiency. The refrigerant compressors may be driven by steam turbines during the summer months, thus providing a steady steam load during an otherwise slack period. Also, a steam-heated absorption type of refrigeration plant may be used in lieu of the refrigerant compression type plant.

PLANNING COSTS

Whether or not steam is used depends upon the relative costs of generating steam in the hospital and purchasing electric power. This possibility should not be overlooked in the planning phase of the hospital.

The only major disadvantage of air conditioning is the increased operating costs and the cost of maintaining the equipment. These costs depend, in large part, upon the type of building, the equipment installed, and the locality. In New York, the capital costs will average approximately 35c to 50c per square foot per year, and operating costs, 10c to 25c per year. The larger the building, the lower the operating costs per square foot. For package or window units, installed in existing buildings, the capital costs are slightly less, but the operating costs are higher.

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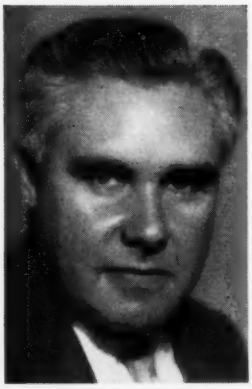


Consultant's Corner

By John G. Steinle

Q. How much space is usually planned for dietary departments?

A. The size of the food service or dietary department should be from 28 to 32 square feet per bed.

Q. Do you know of any good method of explaining simply the reasons for rising hospital costs?

A. I would like to commend for your consideration the following sampling of costs, published in the annual report of Long Island Jewish Hospital, New Hyde Park, N.Y.

	Cost in 1954	Cost in 1957	Percentage of increase
Medical, Surgical Supplies			
Syringes, 20 cc; per doz.	14.00	20.40	45.7
Latex surgical gloves; per doz.	4.90	5.65	15.3
Ace bandages—4"; per doz.	9.25	10.75	16.2
Drainage tubes; each	.38	.55	44.7
Surgically cleaned Chix; per case	10.20	14.40	41.2
Finger cots; per gross	.65	.90	38.5
Catheters, 5 cc; per doz.	29.50	34.20	16.0
Safety stretchers; each	90.00	130.00	44.4
Steel utility carts; each	29.00	37.00	27.8
Safety belts; each	4.00	5.80	45.0
Thermometers; per gross	45.00	54.00	20.0
Soap, 1½ oz. size; per case	6.20	7.45	20.2
Drugs			
Codeine, HCL flakes; per oz.	10.90	14.40	32.1
Dextrose, USP; per 200 lbs.	18.75	37.50	50.0
Terramycin, ointment; per doz. bottles	7.56	9.50	25.7
Instruments			
Tonsil forceps; each	4.00	5.80	45.0
Ophthalmoscope and otoscope set; each	40.00	52.00	30.0
Food			
Chuck beef; per lb.	.44	.56	27.3
Chopped beef; per lb.	.38	.49	28.9
Chuck lamb; per lb.	.29	.40	37.9
Shoulder veal; per lb.	.35	.44	25.7
Cottage cheese; per lb.	.19	.23½	23.7
Eggs; per doz., by the case	.41½	.47	13.4
Oranges; by the crate	6.75	11.00	63.0

Q. In an 80-bed hospital is there any way to avoid operating a boiler during the summer?

A. Some small hospitals have found it advantageous to have a split fuel system. For example, Lynn Hospital, Lincoln Park, Mich., uses oil for heat, gas for hot water, and electricity for steam to operate the ironer in the laundry and the sterilizer in the central sterile supply room. For laundry and sterilization requirements, a separate 220-volt steam generator was engineered for the maximum pressures and capacities to be expected. It can be used when needed without involving high operating costs when steam demands are not at peak. The Lynn installation requires a minimum of controls and I understand that not even a full-time stationary engineer is required.

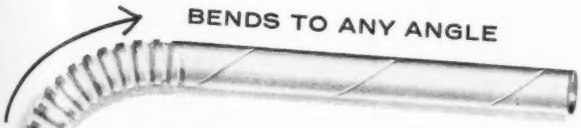
Q. How are newborn deaths computed? What would you consider a high rate?

A. Perinatal rates are determined by the following formula: Fetal deaths (28 weeks and over) plus newborn deaths (up to seven days) times 1,000, divided by live births plus fetal deaths (28 weeks and over). A rate that exceeds 26 per thousand is considered high.

Neonatal rates are often computed and reported. The formula for computation is: Neonatal rate equals all births (alive up to 28 days) times 1,000 divided by live births. Eighteen per thousand is considered an average neonatal rate (Source: New York City Department of Health).

Q. We have a full-time anesthesiologist. He is a diplomate and in private practice. He does his own billing and, in effect, runs his own department. The board is considering recruiting someone else with the same qualifications to be paid as a hospital employee. Do you have any comments?

A. It won't work. It is possible to recruit a full-time anesthesiologist who will agree to be compensated by the hospital, but not in this set of circumstances. Some anesthesiologists will make an agreement with a hospital to fill a vacancy but not to compete with a man already in private practice. In other words, some anesthesiologists will passively go against the mandate of their association but will not do so in a positive manner such as would be required in this situation.



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Review of Hospital Law Suits

Compensation for Injuries

By Leo Parker
Attorney at Law

Hospital officials often ask if damage allowances by higher courts are about the same as compensation awards under the State Workmen's Compensation Act for various kinds of employe injuries. A review has been made of recent higher court decisions illustrating variations between amounts of compensation generally awarded under the State Workmen's Compensation Act and damage allowances for the same relative injuries. Readers should realize, of course, that damage allowances to patients, visitors, guests, and employes of hospitals may greatly exceed awards of compensation under the State Workmen's Compensation Act.

DAMAGE AND COMPENSATION AWARDS

During recent weeks the higher courts in different localities awarded damage allowances in due consideration of, first, the age of the injured person; then, the pain he suffered, the degree of the injury, and future consequences of the injury.

In a majority of states, a State Workmen's Compensation Act specifies definite compensation payments to injured employes and their dependents. These state laws clearly specify the maximum and minimum amounts payable to employes for various injuries, whether temporary or permanent. The disability payments stipulated by these state laws are based upon extensive studies and investigations by experts, and upon due consideration of necessities required by injured employes, their families and dependents. Insofar as I have been able to determine, there has been little or no important change in these laws for several years.

After reviewing these laws in many states I found that they do not materially differ. Let us assume that, in an average state, an employe has, in the past, earned $100 per week, and that he sustains an injury which results in his partial disability. Here are the amounts the employe can receive as compensation, for various injuries:

Loss of thumb, $1,932; loss of finger, $644, loss of hand, $4,000; loss of arm, $7,200; loss of great toe, $920; loss of foot, $4,800; loss of leg, $6,400; loss of sight of one eye, $4,000; loss of ear, $800.

If the employe is permanently and totally disabled, as in loss of both arms, or both feet, or both eyes, he would be paid from a maximum weekly compensation of $32.20 to a minimum of $10 per week, depending upon earned wages until his death. If he dies within two years after the injury, his dependents will receive not more than $32.20 per week, up to a total of $9,000. In other words, the employe's dependents, such as a wife and children, can receive no more than $9,000 for the death of the employe.

In case of temporary total disability, the employe is paid 66⅔ per cent of his weekly wage at the time of his injury. He cannot receive more than $32.20 compensation per week during the period he is totally disabled. And most important is a provision in the state law to the effect that in "no case" shall the employe receive compensation payments for more than six years and never shall he be paid compensation amounting to more than $6,000.

If the employe is partially disabled, the total compensation payable weekly shall, under no circumstances, exceed $4,000.

Therefore, according to this state law, an employe who is totally disabled cannot receive compensation payments, under the State Workmen's Compensation Act, of more than $6,000. If he is partially disabled his total compensation payments are limited to $4,000.

JURY DAMAGE AWARDS HIGHER

I have carefully reviewed awards of *damages*, made by juries and higher courts in different states during the past six months, for injuries to employes and other persons. The results are as follows:

In Davis v. Boldist, 295 S. W. (2d) 941, $45,000 damages was awarded to a 29-year-old laborer who had a knee injury.

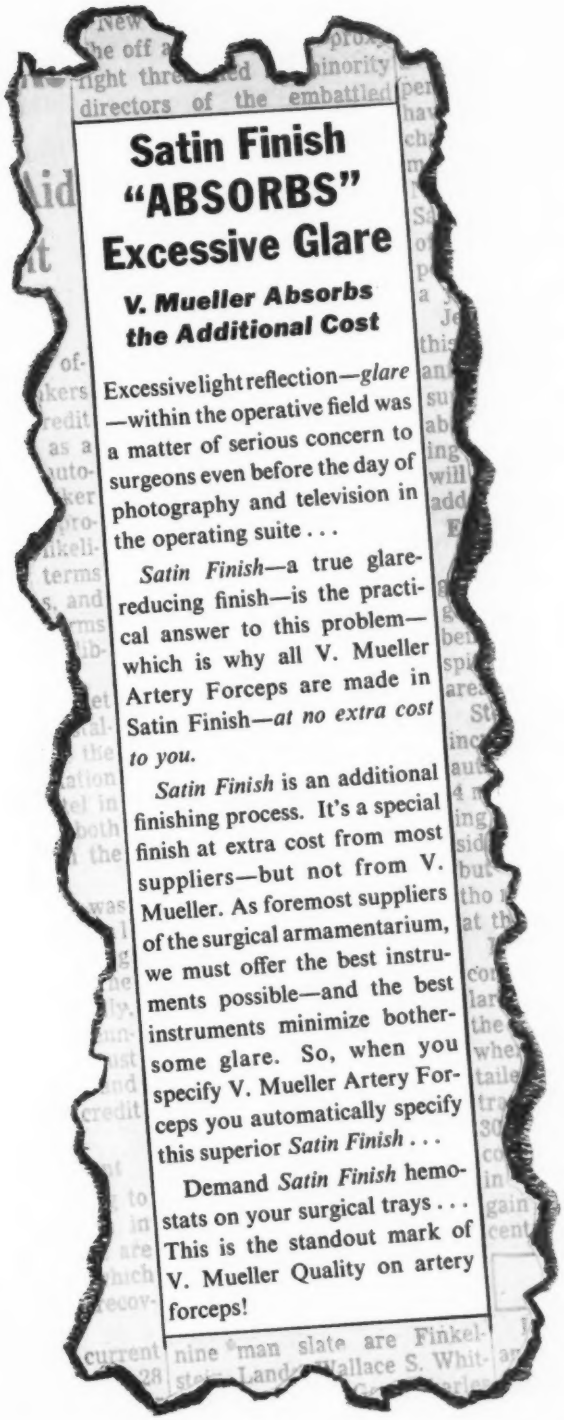
In Taylor v. Montgo, 155 F. Supp. 601, the court awarded $45,000 damages to an employe whose injury resulted in partial loss of vision.

In Federal v. Gulf. 306 S. W. (2d) 171, the higher court reduced a lower court's damage allowance of $39,000 to $34,000 for compound fracture of a patient's leg.

In Buller v. Pelcos, 317 Pac. (2d) 57, the higher court awarded a 70-year-old woman $40,000 damages for a fractured pelvis, four broken ribs, and excruciating pain.

In Hamilton v. Ross, 304 S. W. (2d) 812, the higher court approved an award of $20,000 damages to a 70-year-old business proprietor. The injuries consisted of fracture of the left elbow and deformity of the elbow joint, and general weakness; hospital bills amounted to $1,300.

(Continued on page 46)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HOSPITAL LAW SUITS

(Continued from page 44)

In Evans v. Penna., 154 Fed. Supp. 14, a federal court awarded $67,500 damages to an employe whose life expectancy was 50 years and who had been earning $50 per week before the injury. The testimony showed that, after the injury, it took him eight hours to do the same work he was able to perform before the injury in three hours.

In Ment v. Petal Realty Corporation, 167 N.Y.S. (2d) 328, the lower court allowed a 69-year-old woman $17,000 damages for a fractured arm. The higher court reduced the damage award to $12,500, saying that this amount was sufficient to compensate a person for an arm fracture.

In Allen v. Gulno, 135 Atl. (2d) 904, the lower court awarded a 12-year-old girl $20,000 damages for leg lacerations. The higher court approved the allowance, saying that her life expectancy is 60 years and that she may have to spend $1,000 for plastic surgery to remove the scars.

In Cox v. Chicago, 84 N. W. (2d) 263, the higher court allowed $75,000 damages to an employe who suffered a dislocated and fractured shoulder and a pelvic fracture.

In Hubbard v. Long, 152 F. Supp. 1, a federal court awarded $226,000 damages to a 23-year-old man who had sustained the loss of both legs below the knees. He would have earned approximately $5,500 per year if he had not sustained the injury.

For further comparison, see Farmer v. Hooks, 239 Fed. Rep. 547. In this case, a federal court awarded $114,295 damages to an ordinary workman for injuries which would permanently prevent him from carrying on his former work.

In Butler v. General, 143 F. Supp. 461, the lower court awarded $200,000 damages to an employe whose leg was amputated. The higher court reduced the damage allowance to $160,000.

In Turner Company v. Haulihan, 240 Fed. Rep. (2d) 435, $150,000 damages was awarded to a 39-year-old employe who sustained a compound fracture of one leg and spent 15 months in a hospital.

MEMO TO:

THE HOUSEKEEPER

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Turn to page 37

In Irvin v. U. S., 148 Fed. Supp. 25, $42,505 damages was awarded to an employe who sustained serious injuries to his hip socket.

In Ped. v. Wege, 81 N. W. (2d) 49, a 36-year-old employe was awarded $30,000 damages for a cranial injury.

In Tant v. Stork, 158 N.Y.S. (2d) 595, a higher court awarded $80,000 for ordinary injuries to a 56-year-old woman who had earned $35 per week before the injury.

In Hayter v. Winder, 295 S. W. (2d) 730, a higher court awarded $20,000 damages to a 56-year-old employe hired to keep the premises clean. She sustained a back injury which prevented her from doing hard work in the future.

In Le Beck v. Jarvis, 145 F. Supp. 706, the higher federal court awarded $350,000 damages to a 34-year-old employe who suffered permanent injuries to his legs and extraordinary pain.

In Desh v. Atchison, 300 Pac. (2d) 910, an employe was awarded $365,000 damages by the lower court for injuries which made him unable to earn future money in his trade. The higher court reduced the damage allowance to $290,000 and said:

"The verdict is undoubtedly high. Nevertheless it is not the function of the reviewing higher court to interfere with a jury's award of damages unless it is grossly disproportionate to any reasonable limit of compensation..."

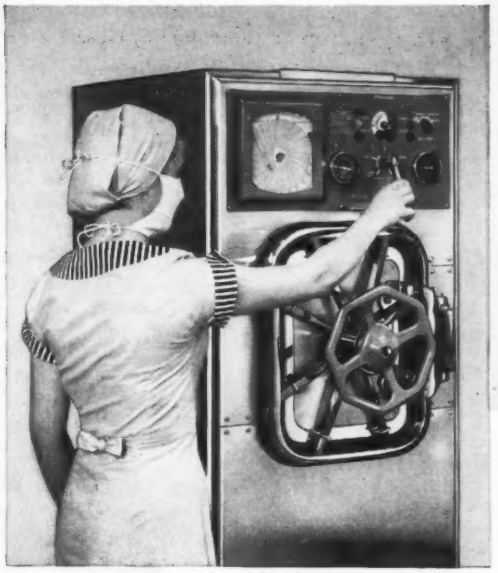
HOSPITAL LIABLE FOR COMPENSATION

Charitable hospitals in all states are bound to pay compensation to injured employees, under the State Workmen's Compensation Act.

In Brewer's Case v. Supreme Judicial Court, 141 N. E. (2d) 281, it was shown that a student nurse paid her tuition to a charitable hospital but was required to work regular shifts in addition to attending classes. Her duties included bathing patients, cleaning equipment and rooms, and preparing and serving meals. One day she was injured while performing these duties.

In subsequent litigation, the higher court held that the injured nurse was entitled to receive compensation, under the State Workmen's Compensation Act, and said:

"Admittedly the hospital was a 'charitable institution.' The question whether a student nurse performing duties of the sort here involved is an 'employee' of the hospital where she receives her training is a question of first impression. It has uniformly been held that a student nurse is an employee. We are of the opinion that the claimant prior to her graduation was a 'laborer or a workman.'"



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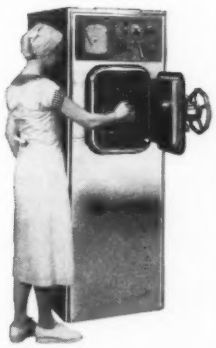

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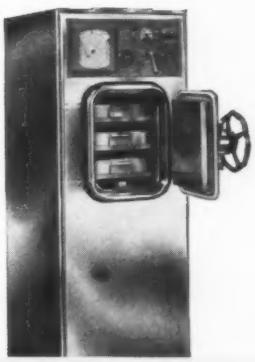

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Personally Speaking

Leo C. Bargielski—has been appointed assistant administrator. St. John's Hospital, Springfield, Mo. He has been in residency training at St. Joseph's Hospital, Fort Worth, Tex., for the past year.

Jerry Bekebrock—succeeds **Meryl Lewis** as administrator, Barton County Hospital, Lamar, Mo.

Cephus Buck—formerly chairman of the board, Umatilla (Ore.) Hospital, has resigned to become administrator of the hospital.

Melvin Dunn—is new director, Children's Mercy Hospital, Kansas City, Mo. He was formerly director, St. John's Episcopal Hospital, Brooklyn, N.Y.

Mrs. Pierina Egan—administrator, Nassau General Hospital, Fernandina Beach, Fla., has resigned. **John Page,** board chairman, is acting superintendent.

Hugh R. Ennis—succeeds **Lee Stilwell** as administrator, Chillicothe (Mo.) Hospital.

O. C. Estes—former administrator, McAlester (Okla.) General Hospital, succeeds the late **Everett Moody** as administrator, Boone County Hospital, Harrison, Ark.

Ernest Erickson Retires

Ernest I. Erickson—retired as superintendent, Augustana Hospital, Chicago, on July 1, after 35 years in that position.

He is succeeded by **Martin H. Hough,** for 10 years assistant administrator at the hospital.

A founding member of the American College of Hospital Administrators, Mr. Erickson has been active in organizational work. He plans to devote a portion of his time to the building program at Augustana, which is expected to reach completion late this year.

Wallace Favorite—is new administrator, Springdale (Ark.) Memorial Hospital, succeeding the late **Curtis Gage Lewis.** He was formerly administrator, Saline Memorial Hospital, Benton, Ark.

Robert E. Fore—is now assistant administrator, Georgia Baptist Hospital, Atlanta, succeeding **Ben Brewer,** who has been named administrator, Western Baptist Hospital, Paducah, Ky.

William W. Given—is new business manager, Carbondale (Ill.) Clinic. He was formerly business manager, Carmi (Ill.) Township Hospital.

E. Grey Gooby—has been appointed assistant director for professional affairs, St. Luke's Hospital, New York City.

Burton M. Gottlieb—has been appointed assistant administrator, Monmouth Memorial Hospital, Long Branch, N.J.

Jack A. L. Hahn—superintendent, Methodist Hospital of Indiana, Indianapolis, received an honorary doctor of laws degree from Evansville (Ind.) College at commencement exercises in June.

Mrs. Nora Hall, R.N.—has been appointed director, volunteer serv-

(Continued on page 49)

Pictured below are students in hospital administration, Northwestern University, Chicago, who have been appointed to administrative residencies for the coming year. Front row (l. to r.): Robert F. Gilmore, George W. Jackson, Morris Parrish, John Stocking, Ronald H. Wilson, Harry Eliazarian. Second row: Roger W. Weseli, John C. McGreevy, Jerome M. Kasdan, Selma N. Earle, Charles U. Letourneau, M.D., and Laura G. Jackson, director and associate director, program in hospital administration, Frederick L. Gibson, Herbert P. Neef, Alan H. Toppel, Joseph A. Saunders. Third row: Edward L. Olson, Peter R. Mariani, Lloyd J. Verret, Richard M. Warren, John H. Schill, William L. Benson, William J. Allen, Jack L. Samuels, Capt. William F. Baker, Joseph L. Faletra, Roland E. Kohr, Gerald M. Krantz, James V. Dorsett, Jr., Rolin H. Johnson, Louis J. Lonni, Robert A. Tittle, James F. Shepherd, Melvin A. Lyons. Fourth row: William D. Hilliard, Charles D. Holland, Robert E. Huesers, Don L. Arnwine, Frank Puntenny, Jr., Leo Reich, James C. Ruthrauff, John P. Certo, Raymond W. Leitner, James R. Horton, Mark E. Wittock, Karl D. Glunz, Lt. John Frezza, Robert J. Aronno, John L. Stellner, Cyril H. Weagle, Jr. Missing from picture is George Mancuso.

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1. *Holden, W. D.; Krieger, H.; Lewey, S., and Abbott, W. E.: Ann. Surg. 146:563 (Oct.) 1957.*
2. *Elman, R.: J. Am. Dietet. Assoc. 32:524 (June) 1956.*

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Roy E. Brown (l.), superintendent, University of Chicago Clinics and Hospitals and director, Graduate Program in Hospital Administration, received an honorary Doctor of Humanities degree from Wake Forest College, Winston-Salem, N.C. Mr. Brown, a past president of the AHA, was formerly a professor at Wake Forest College. Pictured with him are (second from l.): Dr. Harold Tribble, president, Wake Forest College; Reid T. Holmes, administrator, North Carolina Baptist Hospital, and C. C. Carpenter, M.D., dean, Bowman Gray School of Medicine of Wake Forest College.

PERSONALLY SPEAKING

(Continued from page 48)

ices, St. Joseph's Hospital, Stamford, Conn.

Thomas J. Hartford, Jr.—has become assistant administrator, Norton Memorial Infirmary, Louisville, Ky., succeeding **Wade Mountz** who has been named administrator. Mr. Hartford has been serving his administrative residency at the infirmary prior to receiving his M.A. in hospital administration from Washington University, St. Louis.

Ralph P. Hebert—has resigned as administrator, Tri-State Memorial Hospital, Clarkston, Wash., to become business manager, Yakima Valley State School, Selah, Wash.

Fred Hinchee—succeeds **J. Gordon Goree** as administrator, Shawnee (Okla.) City Hospital.

Fred Kohler Holbrook—has been appointed administrator, Riverside County General Hospital, Riverside, Calif. He will assume the administrative phases of the position vacated by the resignation of **Bruce Summers, M.D.,** and a physician will be named to superintend the medical-surgical phases.

Mr. Holbrook was previously administrator, Booth Memorial Hospital, Flushing, N. Y.

Lee Hough—has been appointed administrator, McAuley Hospital, Coos Bay, Ore. He succeeds **Joseph L. McGovern,** who resigned to accept an administrative post in a Chicago hospital.

James P. Hopkins—former public relations director, Florida Citrus Commission, has been appointed public relations director, Orange Memorial Hospital, Orlando, Fla.

Mrs. Maudie L. Horne, R.N.—has been appointed director, Intermountain Unit, Shriners Hospitals, Salt Lake City. She had previously served in the Spokane, Wash., and Lexington, Ky., units, Shriners Hospitals.

Mrs. Ethel Housholder—former administrator, Pushmataha Hospital, Antlers, Okla., is new administrator, McCurtain County Memorial Hospital, Idabel, Okla. She succeeds **Jack Rue.**

Joseph I. Hutchinson — has resigned as executive housekeeper, Baptist Memorial Hospital, Jacksonville, Fla., to become assistant director, Church Home and Hospital, Baltimore, Md.

Robert A. Ivy is president, Southeastern Hospital Conference. He is administrator, Doster Hospital and Clinic, Columbus, Miss.

(Continued on page 104)

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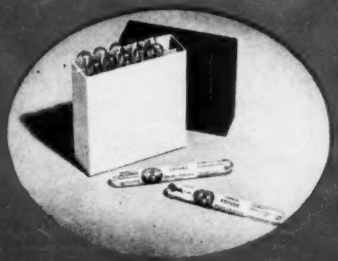

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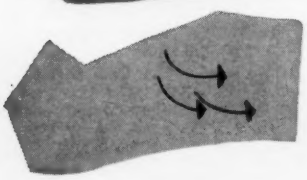

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The Pharmacy

This month TOPICS introduces a new department, "The Pharmacy," designed to bring together under one heading, news, articles, and ideas of special interest to hospital pharmacists. A monthly feature will be "Prescription Pad." Included, also, will be noteworthy clinical news for pharmacists as well as other hospital readers. We will welcome your contributions and suggestions for material you would like to appear on these pages in the future.—*The Editors.*

AMA Council Rejects Color Coding of Liquid Drugs

Using color as a coding device for liquid drug preparations is "more likely to contribute to than to prevent confusion," asserts the American Medical Association Council on Drugs.

In a special report in the April 19, 1958, issue of *The Journal of the A.M.A.*, the council points out several drawbacks to the suggestion that dyes be added to certain medicinal solutions as an aid to their identification and safe use in hospitals.

The council raises the question of whether dangerous confusion might not follow if different hospitals applied different colors for the same preparations. Further, the council notes, the Food and Drug Administration has discouraged addition of dyes for coloring solutions because of lack of adequate information concerning their compatibility and nontoxicity for this use.

Other objections noted by the council include: "the practical limitations of the visual spectrum for achieving distinction between the vast number and kinds of preparations"; the already widespread use of colored medications for different purposes; the handicap of color blindness; the use of light-protective colored glass containers for some drug preparations.

Recommended by the council as the best solution to the problem of mistakes in identity and improper use of solutions and drugs is greater emphasis on education of health personnel and patients to consult and apply "properly informative labels." Container labels, the council urges, should display, legibly and prominently, the name or active ingredient, the potency, and the dosage of the drug. Other details should be presented in a separate package enclosure, the council adds.

Meprobamate Study Indicates Abstinence Reactions to Drug

Warning that tolerance to meprobamate may develop and that abstinence reactions may appear when the drug is withdrawn, is given by Haizlip and Ewing in *The New England Journal of Medicine* 258: 1181-86 (June 12, 1958).

In a double-blind study, using three groups of 25 patients, the authors administered, respectively, identical placebos, 6.4 gm. meprobamate daily, and 3.2 gm. of the drug daily. They noted severe sedative effects during the first three days of administration of the drug, with 35 of 47 patients showing staggering gait or inability to stand or walk without falling.

After 40 days, the authors switched all patients, without their knowledge, to placebos, and noted objective evidence of an abstinence syndrome in 44 out of 47 patients who had previously received meprobamate.

The typical withdrawal syndrome included various degrees of insomnia, vomiting, tremors, muscle twitching, anxiety, anorexia, and ataxia. Eight patients showed symptoms resembling delirium tremens and in three patients, grand-mal seizures developed.

The investigators conclude from their study that meprobamate closely simulates the barbiturates in action and has definite advantages over that class of drugs. However, they recommend starting meprobamate slowly and discontinuing it gradually to prevent withdrawal symptoms.

prescription pad

Dermatologic Ointment

E. R. Squibb & Sons has introduced Myconef Ointment for skin conditions in which anti-inflammatory and anti-pruritic action is indicated in addition to antibacterial and specific antifungal therapy.

Designed for topical use, Myconef contains, in each gram, neomycin base (as the sulfate), 2.5 mg.; gramicidin, .25 mg.; nystatin, 100,000 units; and fludrocortisone acetate, 1 mg.; all combined in Squibb plasticized hydrocarbon gel, Plastibase.

Myconef Ointment is supplied in 15-Gm. tubes.

New Iodophor Germicide

Ioclide is new, nonselective, water-soluble iodophor germicide introduced by Clay-Adams, Inc.

Nontoxic in use dilutions, Ioclide is recommended by manufacturer for activity against spores, viruses, and bacteria, particularly the more resistant strains. It is said to be effective against tubercle bacilli and

(*Continued on next page*)

staphylococci, even in low dilutions, within two minutes.

Ioclide is supplied in 26 ml. glass bottles, and in pint and quart size polyethylene bottles. Plastic caps on pint and quart bottles provide 26 ml. measuring device.

Prantal Cream Now O.T.C.

Schering Corp. has announced that Prantal Cream, for topical management of minor skin disorders, is no longer a prescription item and will be available for direct sale to public. The product is supplied in 50-gm. and 20-gm. tubes.

Cardiac Agent Name Changed

Wynn Pharmacal Corp. has announced that Dura-Tab S.M. Quinaglute is the new name for its sustained action cardiac medication formerly known as Dura-Tab S.M. Quinidine Gluconate. Change was made to avoid confusion and provide greater clarity.

The product is available in 5-gr. tablets, in bottles of 30, 100, and 250.

For Scalp Conditions

Theraderm, formerly called Theradan, is for treatment of seborrhea of the scalp, cradle cap, and associated conditions in adjacent areas. It is a clear, mildly scented alcoholic solution of polythionates and a wetting agent.

The formula contains: bis-(lauryltrimethylammonium) - polythionate, 3 percent, and tetradecylamine n-lauroyl sarcosine, .5 percent, both by weight; and ethyl alcohol, 68.86 percent by volume.

Theraderm is supplied in 5½-oz. bottles by Bristol-Myers Products Division.

Faster-Acting Penicillin

Pen-Vee K (penicillin V potassium), introduced by Wyeth Laboratories, is a new form of oral penicillin with high solubility, which facilitates obtaining blood levels rapidly.

Pen-Vee K is supplied in tablets of 125 mg. (200,000 units) and 250 mg. (400,000 units) each, in vials of 36.

New Dosage Forms

Medrol, anti-inflammatory corticosteroid, has been introduced in 2-mg. tablet size by the Upjohn Co. to permit more exact dose adjustment. Chemically, Medrol is 6-methyl-delta-1-hydrocortisone.

* * *

Gantrisin Cream, containing 10 percent Gantrisin sulfisoxazole, is available in new package form containing 3-oz. tube of cream and 18 disposable applicators. Manufactured by Roche Laboratories, division of Hoffmann-La Roche Inc., Gantrisin Cream is for treatment of vaginitis, cervicitis, and related gynecological disorders.

* * *

Wyeth Laboratories has added three narcotics to its Tubex line of closed-system medications for injection. Codeine phosphate, meperidine hydrochloride, and morphine sulfate are now available in 1-cc. doses.

* * *

Dramamine-D is new dosage form, introduced by G. D. Searle & Co., combining 50 mg. of Dramamine with 5 mg. of dextro-amphetamine sulfate to provide mental alertness with control of nausea and dizziness. Orange-colored tablets are available on prescription only in bottles of 100 and 1,000.

Everybody's talking about Staph...

. . . and with good reason. Staph is a *real* trouble maker. Staphylococcus aureus—to be more formal—is vicious. It invades every part of the hospital. Wherever there are people, it can multiply. In dust, staph lives for weeks waiting to re-infect.

Once staph gets on the loose, there's no telling where it may turn up next . . . operating rooms . . . nurseries . . . patient rooms . . . laundry . . . food service. Among insidious troubles it can cause are postoperative wound infection . . . staphylococcal pyoderma . . . puerperal mastitis . . . staphylococcal pneumonia and enterocolitis.

(Editor's note: In fact, staph infection can pave the way for strep infection, too. If strep gets into a wound with antibiotic-resistant staph . . . parenteral penicillin won't stop or prevent strep infection even when the strep organisms are penicillin sensitive.)

Stopping staph troubles—or never letting them start—that's the problem. Careful attention to *total* environmental asepsis. . . critical evaluation of disinfection procedures and the disinfectants used . . . is an important part of the answer.

Take Lehn & Fink disinfectants, for instance. All three—Lysol®, O-syl®, and Amphyl®—kill even antibiotic-resistant staph. Besides being staphylocidal, they kill all pathogenic organisms . . . including fungi and TB bacilli . . . commonly known to cause cross infection in hospitals.

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Mechanical refrigeration with hold-over cooling capacity for a full hour *without* running compressor or blower. Will hold and retain 38° F. even in room temperature of 90° F.

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S-3002-MR	(24 trays)
S-3003-MR	(30 trays)

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S-3001-DP	(20 trays)
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- **an unobstructed set-up area** *convenient* counter height, at 41″ for 20-meal cart, at 44″ for 24-meal cart. Accommodates large trays up to 15½″ x 20½″.
- **all stainless steel, double-walled, fully-insulated construction throughout.** 2½″ insulation between hot and cold compartment.
- **compact heated drawers** accommodating three 9″ dinner plates, *plus* three 5½″ plates, *plus* three coffee or tea cups
- **an oven compartment** with internal, waterproof installed, stainless steel, sheathed sealed heaters. Accessible *without* dismantling or turning cart upside down. Provides uniform temperatures (185° F.) throughout compartment.
- **fully-insulated, recessed and double-walled doors** of oven compartment close tightly against recessed frame. Full-length *stainless steel* piano hinges on doors.
- **rugged, compact tray slides** that can be removed in easy to clean *sections*, providing clearance between tray slides of 3¾″ for ½ pint "carton-type" milk container.
- **models in 20, 24 and *30-meal size,** for both *mechanical* and *eutectic* refrigeration (Dole cartridge), and with or without beverage dispensers.

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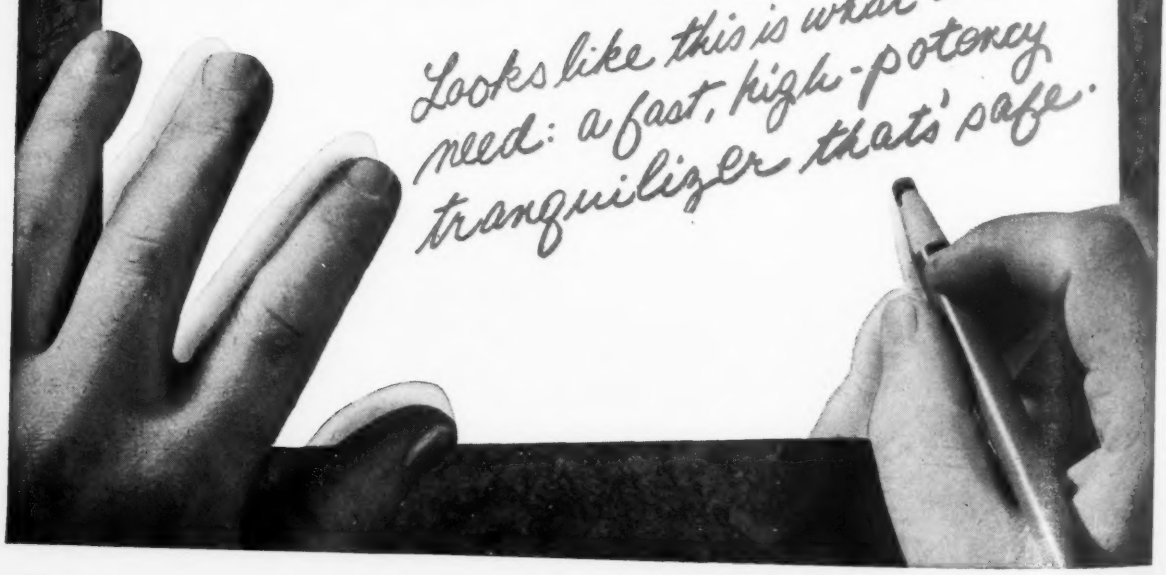

Evaluation of Thyroid Function Tests

By Norman H. Engbring, M.D.*

• In the field of thyroid disease, there is frequent argument and confusion about the relative value of the various tests of thyroid function. These tests include determinations of basal metabolic rate, serum protein-bound iodine, and radioactive iodine uptake.

To evaluate each of these properly, one must first understand what the test measures. One should also be acquainted with the technical problems which affect the reliability of the test and consequently its value to the practitioner.

A brief review of thyroid physiology will aid in understanding the function measured by each of the tests. Iodine ingested in food is absorbed from the gastrointestinal tract into the blood. The thyroid gland, having a marked affinity for iodine, rapidly takes it up from the blood. Excess iodine is excreted from the body via the kidney. These factors form the basis for the *radioactive iodine uptake study.*

Within the thyroid gland, the iodine is incorporated into the hormone, thyroxin. When thyroxin is released into the blood, it immediately becomes bound to serum protein and circulates as a thyroxin-protein complex. The *protein-bound iodine determination* is based upon measurement of the iodine in this thyroxin-protein complex.

The circulating hormone is distributed throughout the body where it exerts an effect on the regulation of cellular metabolism. This rate of metabolism is reflected in the *basal metabolic rate determination* which consequently gives an *indirect* indication of the amount of thyroid hormone present in the body.

A number of other laboratory tests also aid in the diagnosis of thyroid disease.

1. The *blood count* is frequently of value. Hypothyroidism is usually associated with anemia. The hyperthyroidism of Graves' disease is often associated with lymphocytosis.

2. The *serum cholesterol* level is usually increased in hypothyroidism and often decreased in hyperthyroidism. Hence, this test can be of considerable value.

3. *Serum proteins* are frequently altered, the albumin often increasing in hypothyroidism, and the globulin increasing in Hashimoto's thyroiditis.

4. The *erythrocyte sedimentation rate* is increased in cases of subacute thyroiditis.

Although none of these tests is by any means specific or, by itself, diagnostic, each serves to fill a gap in the diagnostic puzzle and help complete the picture.

BASAL METABOLIC RATE

Undoubtedly, the most widely used test of thyroid function has been the basal metabolic rate. Facilities for performing this test are generally available in hospitals, clinics, and private offices. The test is relatively simple to perform and its technic must be familiar to most of you.

The major requirement in obtaining a valid determination is that the patient must be in a "basal" condition—that is, he must be fasting, well-rested, and relaxed. It is often advisable to do the test on at least two occasions to insure that the apprehension of the patient has not contributed to a rise in the metabolic rate.

The range of normal values for the BMR extends from minus 20 percent to plus 15 percent, with the majority of normal individuals falling within the minus range. There is considerable overlapping with abnormal values at either end of the scale.

Unfortunately, the metabolic rate is not affected solely by thyroid hormone activity. Values may be in the subnormal range, in spite of normal thyroid function, in patients with nephrosis or muscular atrophy, or those on restricted diets. More important is the fact that conditions other than hyperthyroidism frequently cause elevation of the basal metabolic rate. These conditions include cardiac or pulmonary failure, malignant tumor, anemia, febrile illness, and trauma. All these might also obscure other findings of hyperthyroidism.

In spite of its shortcomings, the BMR is of definite value for the diagnosis of thyroid disorders as well as for the follow-up evaluation of patients on therapy. *It should not be forgotten or discarded simply because newer tests of thyroid function are available.* It is particularly useful when these newer tests have been rendered invalid for some reason.

PROTEIN-BOUND IODINE TEST

The serum protein-bound iodine determination, when performed accurately, is the most valuable diagnostic test of thyroid function. It measures the amount of iodine bound to serum protein, which actually is the iodine contained in

(Continued on next page)

*Instructor in Medicine, Marquette University School of Medicine, Milwaukee County General Hospital, Milwaukee, Wis. This article is adapted from a lecture given at the Tri-State Hospital Assembly, held in April in Chicago.

the thyroxin molecule. Consequently the test is a *direct* measure of the amount of circulating thyroid hormone. The amount of hormone in the blood varies directly with the metabolic status of the patient, being low in hypothyroidism and high in hyperthyroidism. The normal range is from 3.5 to 7.0 micrograms of iodine per 100 cc. of serum, with only slight overlapping at either extreme.

Several methods of determining protein-bound iodine are in use today. These methods utilize the same first and final steps of procedure. Detailed descriptions of these procedures are readily available in the literature.

Briefly, the first step is precipitation of the protein and washing of the precipitate to remove unbounded inorganic iodides. Remember that thyroxin remains protein-bound.

The second step involves digestion or ashing—that is, the destruction of the organic material and conversion of the iodine to an inorganic state. The two most widely used methods are wet ashing (acid digestion) and dry ashing (alkali and heat).

The third step involves the formation of an iodide solution either by distillation of the iodine from the acid-digested material, in the wet ashing method, or by dissolution of the iodine, in the dry ashing technic.

The fourth step involves the colorimetric reaction and reading. This reaction utilizes the reduction of the ceric ion, which is yellow, to the cerous ion, which is colorless, by use of the arsenious ion. The process is catalyzed by iodine, and consequently, the rate of decolorization varies directly with the concentration of iodine.

The most reliable, but also the most tedious, method is the wet ashing or digestion process followed by the distillation of iodine. The procedure is, briefly, as follows:

An aliquot of serum is precipitated with zinc sulfate and sodium hydroxide solutions; the precipitate is then washed four times with water to remove inorganic iodides that are not bound to protein. After being washed, the precipitate is dissolved in sulfuric acid; it is then transferred to a flask and digested with sulfuric and chromic acids and heat. After the protein is digested, the flask is cooled and then attached to a Chaney still containing sodium arsenite and sodium hydroxide solutions in the trap. The flask is then heated, phosphorous acid is added to the solution, and the freed iodine is distilled over into the trap solution. The trap solution is collected in a volumetric flask, brought to volume, and the rate of decolorization of the ceric sulfate by arsenious acid is determined.

Many problems are associated with obtaining valid protein-bound iodine determinations. The primary one is that of iodine contamination. Because the test measures a fraction of a microgram of iodine, presence of even the slightest amount of extraneous iodine can make the test worthless. A stoppered bottle of iodine solution in the same room is enough to contaminate the test. For this reason, a separate room, free of iodine, is essential. Likewise, Gram stain solutions in the same or adjacent rooms can contaminate the area sufficiently to distort results.

Water used for solutions or for rinsing glassware must be doubly distilled in glass apparatus or passed through a demineralizing resin to assure purity from iodine. Reagents, although of highest quality, often contain enough iodine to cause difficulty. It is sometimes worth the effort to assay batches of reagents and purchase lots with low iodine content.

Because the procedure for the distillation method is tedious and exacting, a technologist cannot complete more than five or six tests daily, while 20 to 30 determinations using the alkaline ash method may be completed.

Each test should be done in duplicate from beginning to end. If results do not check within 0.5 microgram, the test should be repeated.

At frequent intervals, the reproducibility of the test should be checked by making a determination on a known sample of serum. This sample may be an aliquot of pooled serum, which can be kept for several months if frozen. Another source of standard serum is any normal individual since the PBI remains remarkably constant in a given person from month to month and year to year.

A close liaison between the laboratory and the ward is advisable since this also serves as a method of control.

In addition to contamination from sources of iodine within the laboratory, numerous other factors can cause spurious elevation on the PBI. Many iodine-containing compounds become protein-bound in the blood of patients. These compounds include inorganic iodides, such as potassium iodide and Lugol's solution; organic iodinated compounds used as x-ray contrast media, such as Telepaque, Diodrast, Urokon, or Lipiodol; medications, such as Floraquin; or anti-thyroid agents such as iothiouracil. The complete list is quite long and new compounds continue to be added.

Inorganic iodides, such as potassium iodide and Lugol's solution may cause falsely high values as long, as a month after discontinuation of their use. X-ray contrast media, such as Urokon and Diodrast, used for intravenous pyelography, may elevate the PBI for two months. Telepaque and other gallbladder contrast media may remain in the body as long as six months. Lipiodol, used in bronchography and myelography, may never be completely excreted from the body and hence, may cause permanent elevation of the PBI.

Usually, a discussion with the patient will reveal the presence of these contaminants and the test may be postponed. However, many iodine-containing compounds in frequent use are less well recognized, but will also cause falsely high PBI values. These include certain cough medicines, vitamin preparations, gargles, ointments, and suppositories.

(Continued on page 60)

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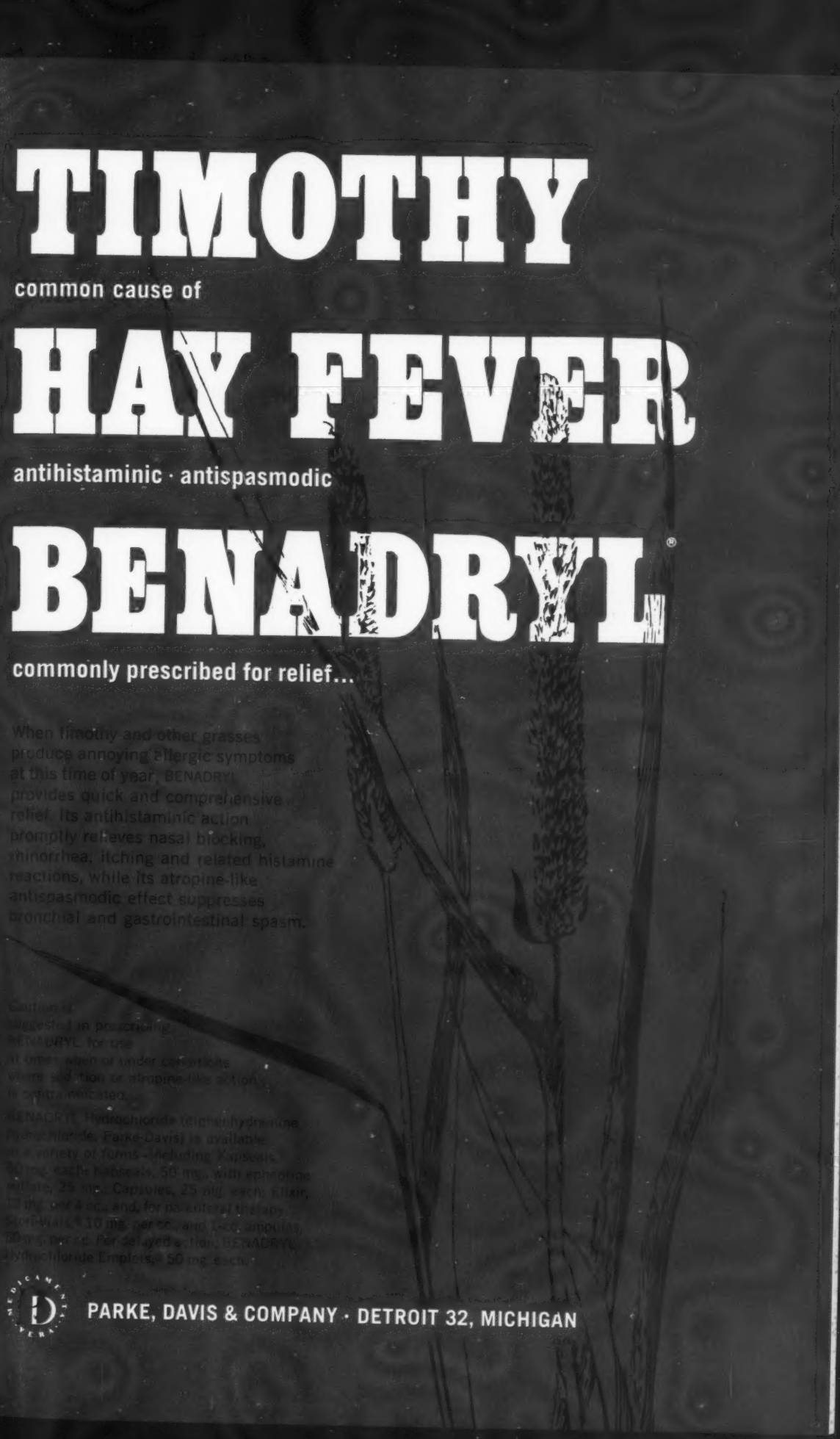

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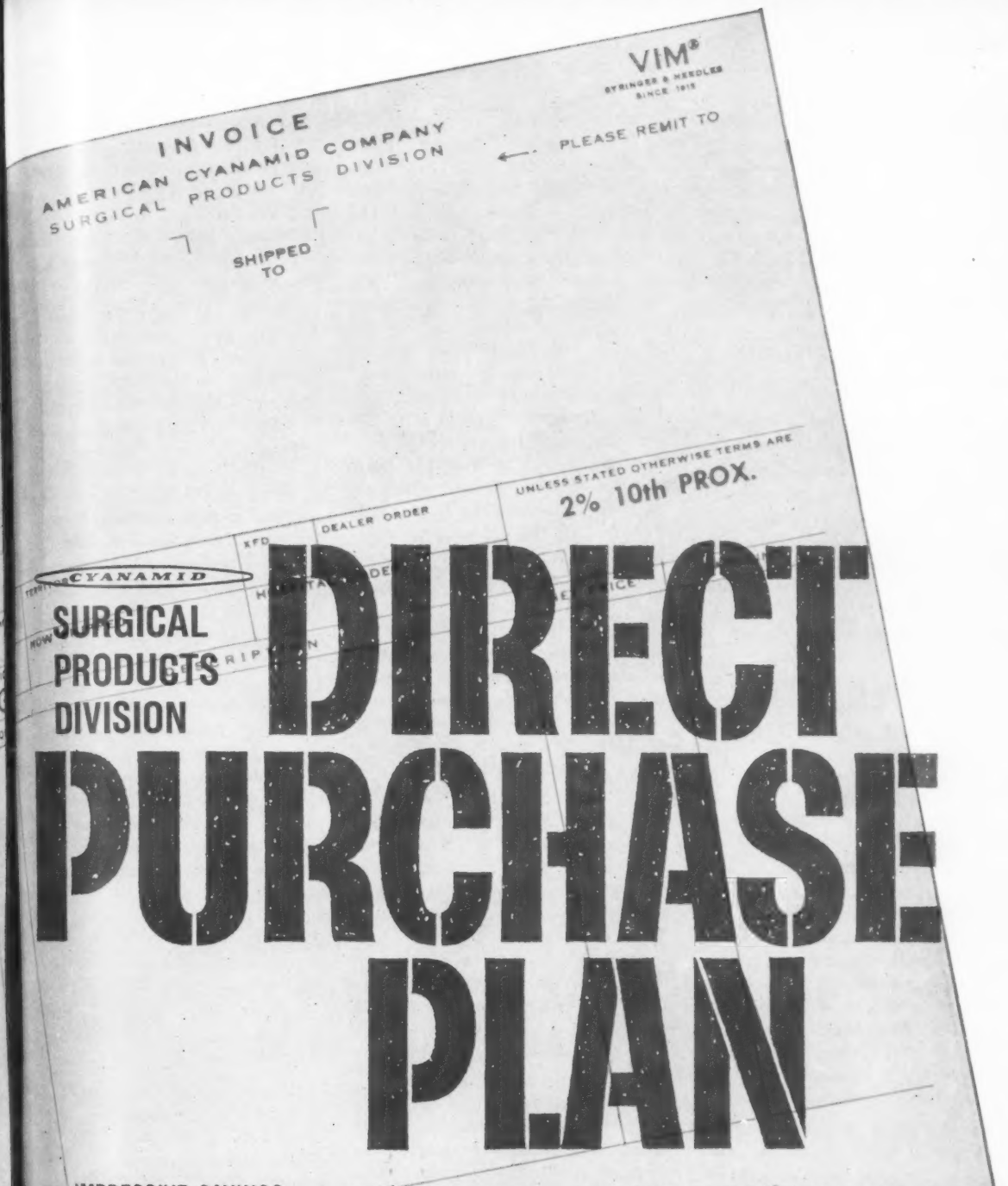

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(Continued from page 56)

It is, likewise, important to remember that an increase in the PBI value is normal in pregnant women and in patients taking estrogens. Under these circumstances, the normal range may extend as high as 12 micrograms percent. Patients taking thyroxin also have values above the usual normal range.

Although the major concern is with false elevation of the PBI, on occasion this value can be falsely lowered. Mercurial diuretics, if given within 24 hours of the drawing of the blood sample, may interfere with the distillation procedure and cause low values. Patients with low amounts of serum albumin frequently show abnormally low PBI values although their thyroid function is normal. Low values have also been observed in persons being treated with Dilantin, testosterone, or triiodothyronine.

The problem of removing inorganic iodine ingested by patients can be solved by doing a butanol extractable iodine (BEI) determination. In this procedure, the serum is extracted with butanol, and the extract is washed with a strong alkali solution which removes the inorganic iodides. The procedure then continues, using the steps of the PBI test including digestion, distillation, and colorimetric reaction and reading. The butanol extraction and washing procedures are considerably more time-consuming than the regular PBI test. Unfortunately, x-ray contrast media cannot be removed even by this procedure.

By this time it must be quite apparent to those unfamiliar with the test that the determination of serum protein-bound iodine is technically complex and is fraught with pitfalls in the form of iodine contamination. Nevertheless, it is the most precise and significant of the thyroid function tests and therefore of greatest value to the clinician. However, if consistently reliable results cannot be produced by the laboratory, then the procedure should be completely re-evaluated or else completely abandoned in favor of some other test of thyroid function. An unreliable result is worse than none at all.

—RADIOACTIVE IODINE UPTAKE

The radioactive iodine uptake test derives its value from the ability of the thyroid to take up iodine with remarkable avidity. The amount of a given dose of radioactive iodine picked up by the gland is a direct measurement of the activity of the gland. In normal, euthyroid individuals, the thyroid gland will contain 10 to 45 per cent of the dose of radioactive iodine 24 hours after its administration. The hypothyroid person with an atrophic thyroid gland will have a low uptake, less than 10 per cent; the hyperthyroid patient will have an uptake greater than 45 per cent. The test also is of value in diagnosing subacute thyroiditis, because, in these patients, the uptake is very low.

The test is relatively simple to administer and results are quite reliable. These factors have caused it to be used widely in the past few years as a diagnostic tool. Radioactive iodine has also played a role in the therapy of thyroid disease.

The procedure for the uptake test is as follows: A tracer dose, 5-20 microcuries, of I^{131} is given orally to a fasting patient. An identical dose is pipetted into a test tube to serve as the standard. The patient is instructed to begin immediately to collect a 24-hour urine specimen. Twenty-four hours after the dose is given, the patient returns for counting of the gamma rays given off by the I^{131}.

The neck is first scanned with a detector at close range to determine whether the iodine is distributed uniformly throughout the gland or whether it is concentrated in a nodule. Likewise, the presence of a nodule which fails to take up iodine is significant. Collimators may be used to help pinpoint small areas of radioactivity. If a neoplasm is suspected, not only the neck area, but the entire body should be scanned to search for functioning metastatic tissue. In such cases, a larger dose of radioactive iodine is given, usually 100 microcuries.

Normally, the iodine uptake is diffused throughout the thyroid, the main concentration being in the isthmus, or center, of the gland. The information on distribution obtained by scanning often is as significant as is the total uptake. The uptake study may be done at any interval from two to 72 hours after administration of the tracer dose; however, the 24-hour uptake determination appears to be the most satisfactory and convenient.

When the percent uptake is being determined, the patient should be positioned so the head and neck remain stationary throughout the procedure. The detector is placed approximately perpendicular to the neck and aimed at the area of greatest uptake. The distance from detector to neck should be carefully measured and should remain fixed for all procedures. The amount of distance depends upon the type of detector used.

The gamma rays given off by the I^{131} in the thyroid are emitted in all directions; many are deflected forward after striking some of the structures in the neck, such as the vertebrae, and their energy is considerably dissipated. To prevent these low energy, "back scattered" rays from raising the total count, a thin lead filter, which will exclude them, may be used. Another method of reducing these extraneous rays in the counts is to use a gamma ray spectrometer or analyzer which counts only the high energy rays proceeding directly from the gland.

The count is taken for a period of one minute; the total number of rays is registered on the scaler.

Correction must be made for background radiation present in the room and in the radioiodine outside the thyroid gland in the patient's body. To do so, the count is repeated, using a lead shield one-half to one inch thick over the thyroid to black its rays out. The background count thus obtained is subtracted from the gross count.

In order to compare the patient's uptake with the standard, which represents 100 percent of the administered dose, the total amount is counted under circumstances identical to those used in counting

(Continued on page 63)

BARDIC®

disposable plastic products in modern polyvinyl

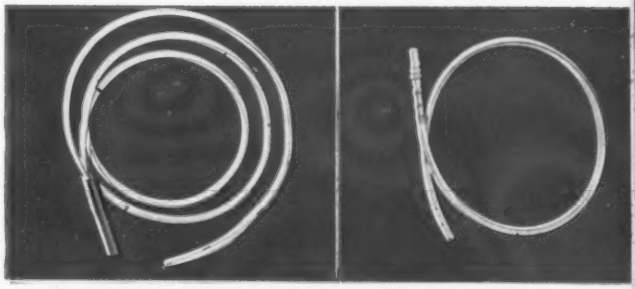
EXTEND HOSPITAL SAVINGS

Appreciable convenience and cost savings in the patient's medical and surgical care are realized with Bardic disposable products. In permitting discard after one use, these disposable sets eliminate the nuisance of reprocessing, more than pay for themselves in important time and labor savings.

Therapeutically, "Bardic" sets are sound, chemically inert, non-reactive to body chemicals. In fact, their formulation of clear, smooth plastic has been found to favor the psychological well-being of the patient. Of special note—their use removes danger of cross-infection.

C. R. BARD, INC. SUMMIT, N. J.

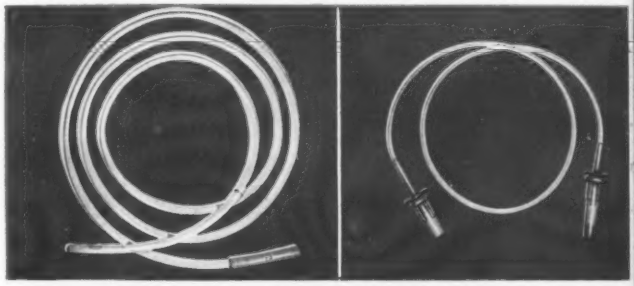
Order from your Hospital / Surgical Dealer



1709 Stomach Tube (Levin type) 50" long. Tube marked at 18, 22, 26 and 30 inches from distal end. 12 and 16 French.

1720 Oxygen Catheter — Tinted green, 16" length, 10 and 14 French.

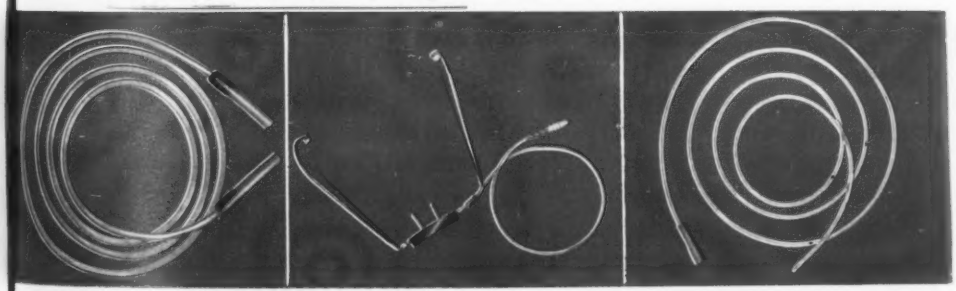
all Connectors are designed to fit standard accessory equipme



1741 Enema or Harris Flush Tube. 24 Fr., 60" length. **1740** Rectal Tube, same as 1741 except 20" length.

1750 Extension Tube. 20" length, sterile an non-pyrogenic. Nylon adapters connect an two pieces of equipment with luer-slip or luer lok fittings.

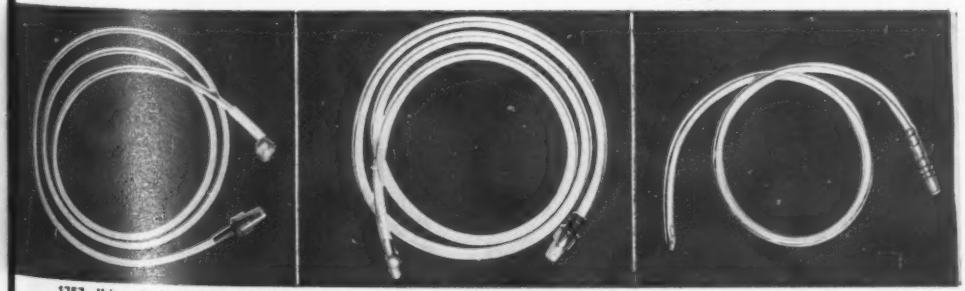
- **clear**
- **smooth**
- **safe**
- **convenient and expendable**



1725 Oxygen Connecting Tube — 60" length tinted green. Flexible connectors at both ends. **1765 Connecting Tube** with female adapters clear plastic, 18" length. **1766** same as 1765, except 60" length.

1727 Oxygen Cannula. Tinted green. Lightweight malleable earpieces insure patient comfort.

1730 Feeding Tube. 8 Fr., 42" length marked 10, 20, 30 inches from distal end. **1731 Infant,** 8 Fr. 15" and Premature Infant, 5 Fr. 15", sterile, non-pyrogenic. **1733 Premature Infant,** 5 Fr. 36"; sterile, non-pyrogenic.



1757 Urinary Drainage tube with bottle connector. 9/32 lumen, 60" length. Sterile, non-pyrogenic. **1754** same as 1757 except 3/16 lumen.

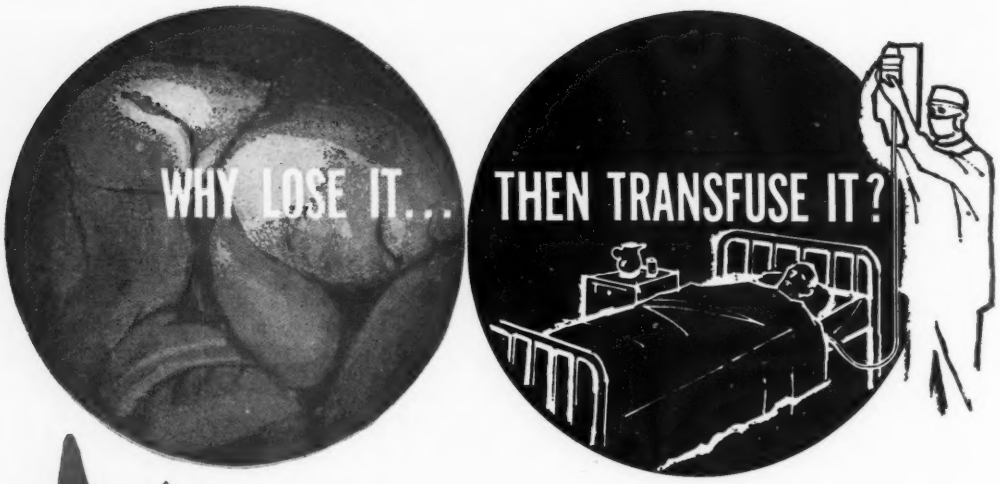
1756 Urinary Drainage Tube. 9/32 lumen, 60" length. Sterile, non-pyrogenic. Tapered adapter connects to indwelling catheter. **1755** same, except 3/16" lumen.

1760 Suction Catheter. Whistle tip with molded eye. Ridged nylon connector, 22" long; 10, 14 and 18 French.

BARDIC®

—the new word in disposable products . . . a companion line, in fine quality and performance, to world-famous BARDEX® Foley Catheters

582 H



REDUCE BLOOD LOSS DURING SURGERY

KUTAPRESSIN®

Kutapressin, a fractional derivative of liver, minimizes capillary oozing and often reduces the need for transfusion.

Surgical procedures, such as tonsillectomies and adenoidectomies, transurethral resections, and even ophthalmologic and brain surgery, are facilitated by improving visibility within the surgical field. The incidence of postoperative hemorrhage is likewise significantly reduced.

In all surgical procedures, Kutapressin promotes better wound healing. Kutapressin does not affect systemic blood pressure, blood clotting or prothrombin time, and there are no untoward effects following its use.

Kutapressin is administered intramuscularly or subcutaneously. Available in 10 cc. and 20 cc. multiple dose vials.

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(Continued from page 60)

the patient. Backscatter and tissue absorption are simulated by using a "phantom neck" which consists of a material having a density similar to that of the human body. Most frequently this is water or plastic. The standard is placed within the phantom and is counted at the proper distance for one minute; the room background is subtracted; then the percent uptake can be readily calculated by dividing the patient's count by the standard count.

The urine volume is measured and an aliquot counted and compared with an aliquot of the diluted standard to compute the percent of the dose excreted in 24 hours. This serves as a double check on the method, the test being valid if a reasonable recovery—70 to 90 percent—is obtained. Edematous patients will retain considerable amounts of radioactive iodine within the body for several days.

Factors which interfere with the uptake of radioactive iodine include the same substances that interfere with the PBI test. These are: inorganic and organic iodides and other medications, such as thyroid substance and anti-thyroid drugs which prevent the uptake of iodine by the thyroid.

There are some other shortcoming of the test, also. In individuals with toxic nodular goiters, only half will have uptake values above the range of normal. Also, some hypothyroid persons, such as those with goiter, and some following surgical thyroidectomy, will have values that fall in the range of normal. These patients must be evaluated by other methods.

The radioactive iodine conversion ratio (PBI^{131}) has been introduced to augment the uptake study. It employs a comparison of the protein-bound radioactive iodine, which represents thyroid hormone, to the total radioactivity of the plasma which also includes the free inorganic radioactive iodide. This reflects the activity of the thyroid gland in that the thyroid has picked up the I^{131}, used it to manufacture thyroxin, and has then released it into the blood. In hyperthyroidism, we find a high conversion ratio, the overactive gland rapidly picking up the radioactive iodine and releasing radioactive hormone. In hypothyroidism, the conversion ratio is low. The normal range is between 8 and 35 percent. This test is not to be confused with the chemical PBI determination, and results cannot be compared.

The test is performed by precipitating the protein in a sample of blood drawn 24 hours after a 100-microcurie dose of I^{131} has been given. The precipitate is washed and the radioactivity is determined and compared with that in a similar aliquot of serum.

Another simpler method employs a resin through which a sample of plasma is passed. In passing through the resin, the inorganic radioactive iodide, sodium iodide, which was given to the patient, becomes bound to the resin while the thyroxin which is bound to protein passes through with the effluent. The conversion ratio is expressed as the per cent of hormonal I^{131} (effluent count) as compared with total I^{131} (plasma count).

The test is of value in certain cases of suspected hyperthyroidism when the thyroidal uptake may be borderline, particularly cases of toxic adenomatous goiters. Generally, however, the results parallel the uptake results.

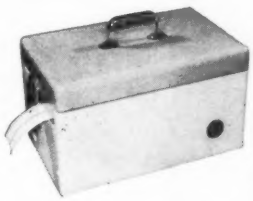
After considering the various aspects of thyroid function measured by the different tests, it should become apparent that *each test fulfills a different need* and consequently each is valuable.

Certainly, the physician who has all three tests available has an unquestionable advantage in establishing a diagnosis in the problem case of thyroid disease.

more accurate diagnosis

THE NEW ALL-NEW BIRTCHER 300

SPEED ELECTROCARDIOGRAPH



Tachycardia, encountered in children and frequently in the aged, makes electrocardiograms difficult or impossible to read. The double speed feature of the new Birtcher 300 Electrocardiograph makes reading these, and all other traces where a double magnification of the horizontal is desirable, more accurate. Dual speed is just one of 19 engineering achievements found in the Birtcher 300 . . . a result of more than 22 years devoted to the manufacture of the finest medical electronic equipment.

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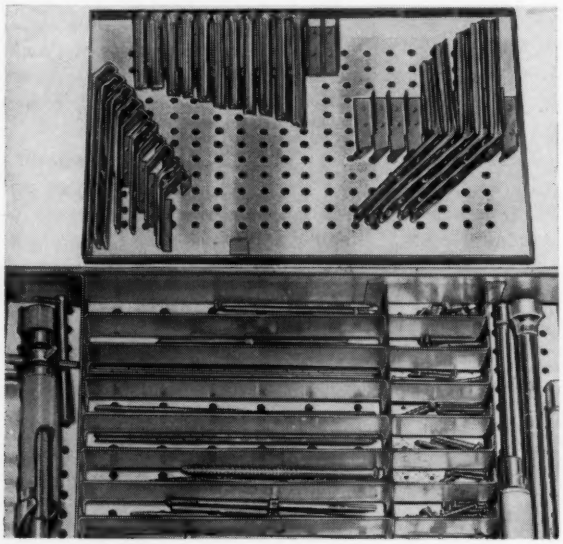
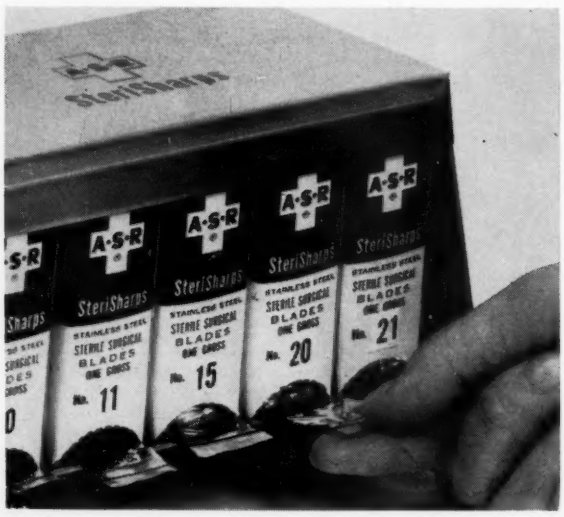


300. Hip set tray

Wright hip set tray is 3-piece unit with removable inner tray. Has nine compartments for Knowles and Steinman pins, hip scews; nine smaller compartments for bone scews, lock screws. Tray holds Smith-Petersen hip nails, Thornton plates, and full assortment of Jewett 1-piece hip nails. Items remain in place when tray is closed. Wright Manufacturing Co.



301. Ultrasonic cleaner

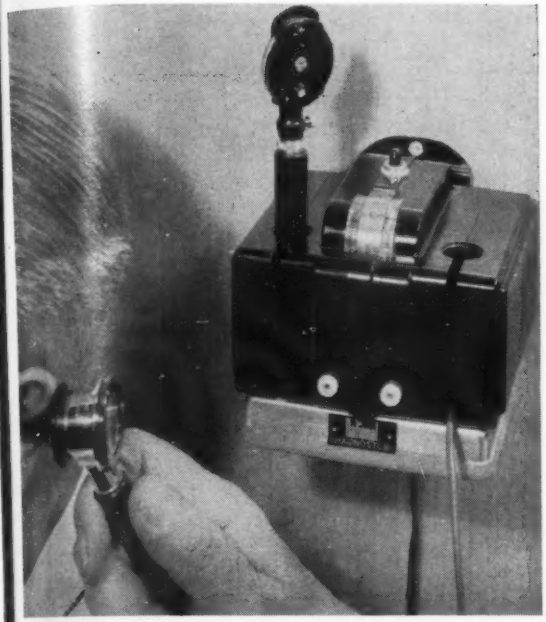
Mass-produced line of low cost, high-capacity ultrasonic cleaners has been introduced. Series 600 line comprises 13 different ultrasonic systems made up of combinations of the SonBlaster generator and ultrasonic transducer models. Stainless steel tanks range from ½ to 1 gallon capacity. Narda Ultrasonics Corp.

302. Germ-proof flooring

Two new Amtico floor coverings which kill or inhibit germs and fungi are now available, with permanent germproofing process known as "Permachem." Offered in Amtico Care-Free, budget-priced, all-vinyl flooring, and Amtico conductive vinyl, static-proof tile for operating rooms, x-ray rooms, and laboratories. Data indicates that Permachem kills on contact gram negative and gram positive bacteria, and spore formers. Also inhibits fungi, including athlete's foot organism. Is odorless, colorless, durable, non-toxic. American Biltrite Rubber Co.

303. SteriSharp dispenser

Any hospital using A.S.R.'s SteriSharp surgical blades will be given sufficient stainless steel blade dispensers to equip the operating room, emergency room, and central supply. Each dispenser holds 5 gross of blades. A.S.R. Hospital Division.



304. Diagnostic lamp

Desk or wall unit holds 2 diagnostic lamps with retractable cords. Molded plastic housing has sockets which hold otoscope or ophthalmoscope securely. Unit also provides connectors for attaching any other conventional diagnostic lamp, including nasopharyngoscope, transilluminator, or proctoscope. Convenient for clinic or busy practicioners who use these instruments frequently. Seven-foot cord reels in and out automatically, can be locked at any point. Engelhard Industries, Inc.

305. Tape dispenser

Heavy duty tape dispenser will be given free to hospitals with purchase of 1 bulk carton (36 rolls of 1-in. by 60 yards) "Scotch" brand autoclave tape and 12 rolls of transparent cellophane tape ½-in. by 2.592 in. Dispenser is heavy enough for easy one-hand operation. Has attractive gray lacquer finish. Autoclave tape holds firmly in high steam temperatures, removes easily without discoloring linen. Minnesota Mining and Manufacturing Co.

306. Absorbent balls

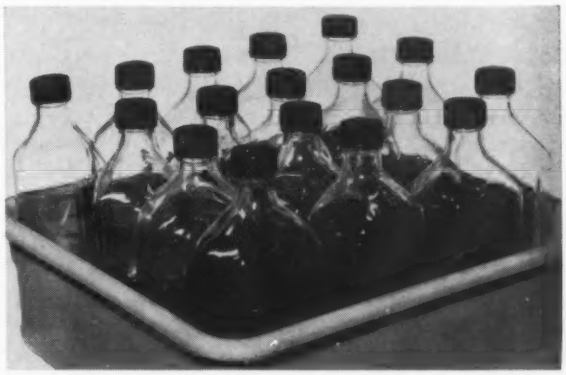
Cotton balls with sponge-like absorbency are made of only long staple fibres of selected virgin cotton, eliminating "wisks" or "strings." Made in five most frequently used sizes. Acme Cotton Products Co., Inc.

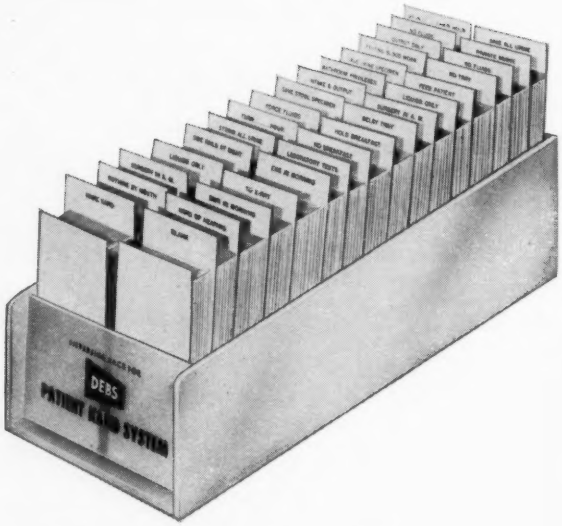
307. Urinalysis set

Ketoset supplies complete equipment, including special glassware and reagents, for determination of adrenal cortical activity by urine analyses. Tests classify hypo-, normal, and hyperactivity. Differentiates hypo-activity into primary or secondary failures by means of ACTH response tests, and differentiates carcinoma from hyperplasia or adenoma in hyperactivity. Reagents sufficient for 200 tests in various combinations. Set also supplies 2 flask heaters and Vapo-Vent for safe evaporation of ethyl ether or other inflammable fluids. Scientific Products, division of American Hospital Supply Corp.

308. Plastic box

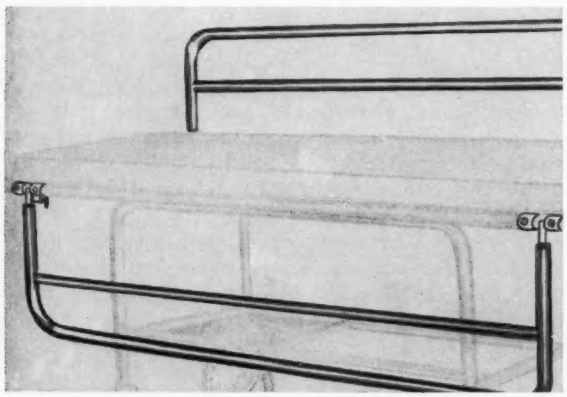
Made of rubberized plastic, Duro box is used for handling hospital materials. Plastic is noiseless, stain-resistant, unbreakable, and will not chip or crack in normal use. Nonporous material will not retain odors, resists most acids, alkalies, and solvents, and cleans easily with detergent or water. Designed for maximum storage, boxes nest deeply. Rolled edges permit easier handling and firm grip. No sharp edges to catch clothing or injure hands. More than 60 sizes and styles are available in standard production; special boxes can be designed to specification. Hollywood Plastic Arts, Inc.





309. Patient care instructions

Patient Kard system consists of self-adhering instruction plaque, pre-printed instruction cards with space for patient's name and room number, and dispensing rack. Cards are 2 in. by 4 in., and are color-coded according to type of instructions—blue for nursing, green for dietary, yellow for laboratory, and white for general. Supervising nurse controls system, dispensing or changing orders. Debs Hospital Supplies, Inc.



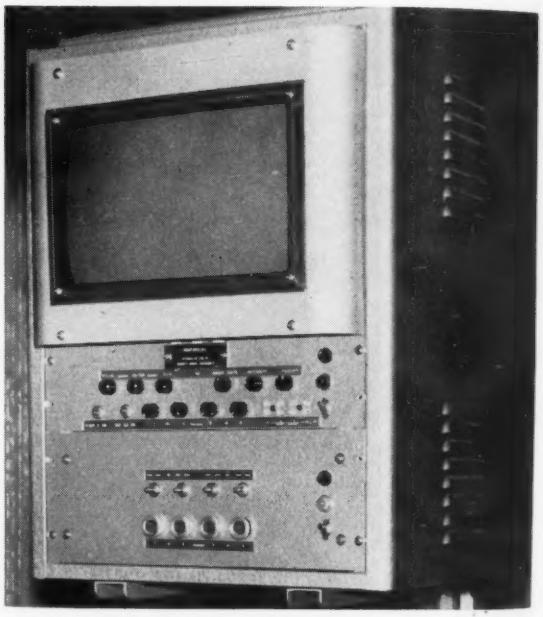
310. Side rails

Hinged side rail is permanently attached to wheel stretcher, ready for immediate use. From hanging or storage, rail is pulled out and up in semicircular motion and placed for use on litter top. Rail may be locked securely with attached pin for further convenience and safety. Readily adapted to all types of wheel stretchers, rails can be installed quickly. Made of stainless steel, they are available in full length (59 in. by 13 in.) with cross member, and short length (37 in. by 10 in.) without cross member. Hausted Manufacturing Co.

311. Fast x-ray processing

Rapid method of processing high-speed x-ray film enables radiographs made during surgery to be read after only 90 seconds processing. Technic utilizes Kodak Royal Blue medical x-ray film with special processing at 80 F. Reduces amount of radiation necessary to make a radiograph by almost half, reducing exposure of patient and personnel in operating room. Radiograph may be examined by surgeon during operation. Films are then returned to processing room for complete fixation and washing. Eastman Kodak Co.

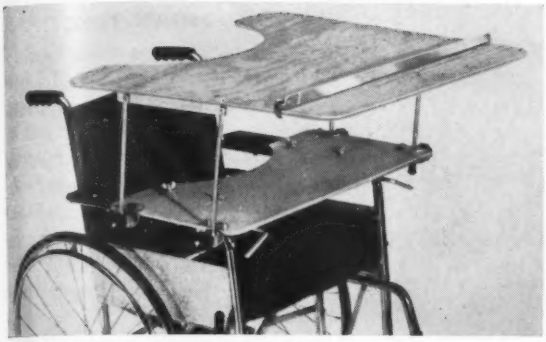
312. Oscilloscope



Large screen, multi-channel, cathode ray oscilloscope, Monitorscope, is basic instrument which makes instantly available maximum information from electrocardiogram, electromyogram, or electroencephalogram of patient undergoing surgery. Mounted on casters, portable unit may be placed away from operating area, yet screen is in full view of everyone in operating room. Has two channels which may be used independently or simultaneously. Interlock system prevents application of power when cabinet is below 5-foot level. Continous contact with conductive floors is provided for static discharge. Essential Electronics Corp.

312a. Body rub, lotion

A new medicated body rub and skin lotion, T.L.C., is a greaseless, stainless emollient available in squeezable plastic dispenser. Containing silicone and hexachlorophene, it relieves bed sores, promotes healing of infections and wounds, and counteracts itching caused by dry skin. Repeated applications minimize skin bacterial population. Water-soluble—avoids interference with normal bathing. Identification space on container for patient's name and room number. Meinecke & Co., Inc.



313. Wheelchair table

Wheelchair table features almost unlimited adjustment, tilting to any position within 9¾ in. to 35°. Has rubber-covered spring clamps. Elevation and tilt adjustment knobs are at side, giving patient freedom of movement. Top fits around patient, leaving room for respirator chest shells. Rehabilitation Products, division of American Hospital Supply Corp.

314. Suction machine

Chaffin-Pratt all-purpose suction machine, Model FA-250, has 2 ranges: low—0 to 4 in. mercury vacuum; high—0 to 23 in. mercury vacuum. Used in low range for operation of Miller-Abbott, Harris, and Levine tubes, as well as genitourinary and chest suctions. On high, operates all types of throat suctions or fields where high vacuum with large air displacement is needed. Of stainless steel and chrome plate, over-all height is 37 in. Pratt Hospital Equipment Mfg. Co.

315. Permanent plaque

"Perma Plaque" is method of permanently preserving documents, diplomas, degrees, certificates, photographs, and other valuable papers. Hermetically seals out air, moisture, other destructive elements. Keeps colors bright, can be cleaned with a damp cloth. No glass to break. Plaque is made in 19 borders, giving wide choice of colors. Perma Plaque Corp.

316. Slippers

"I. Q." slippers are of knitted nylon with elastic ankle band for no-slip fit. Seams and stitches doubly re-inforced for added strength. Sole has composition bottom with rubber-foam insert, which can withstand temperatures of 130° in dry heat or boiling water. Launder easily and dry quickly. Charles Sales Co., Inc.

317. Folding back rest

"Pedangle" folding back rest may be securely fastened, with strap webbing, to any hospital bed. Unit is made of aluminum tube and canvas; is lightweight and folds flat for storage. Especially useful for early ambulation after surgery. Prevents complications in the aged and in heart patients for whom minimizing exertion is important. Zimmer Manufacturing Co.

318. Saturated towels

"Wash 'n Dri" towel is hermetically sealed, saturated antiseptic tissue for bedside use. Saves attendants' and nurses' time in washing and bathing patients. Easy to open, no towel needed, dries in seconds, leaving skin smooth and clean. Useful for bathing children, cools and comforts patients after surgery, childbirth, or dental extractions. Packed 2,000 per carton. R. R. Williams, Inc.

319. Operating room light

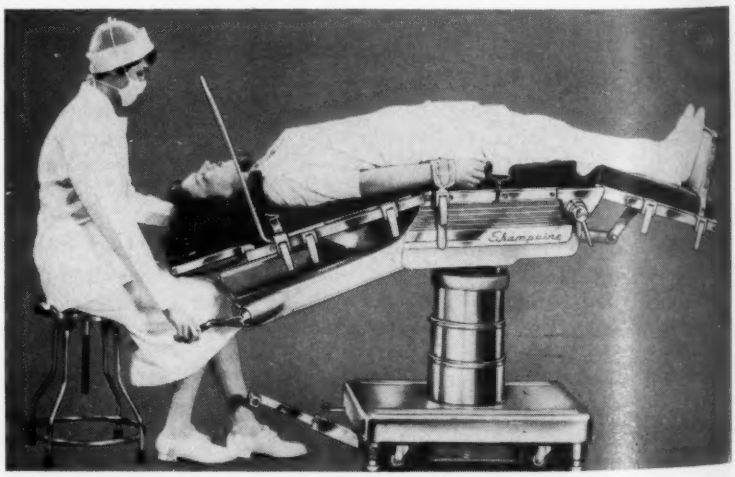
Fluorescent lighting system for operating rooms provides high light levels without discomfort by utilizing asymmetric beam. Prismatic controlled beam concentrates light on and around operating table while providing uniform, comfortable, shadowless general lighting throughout entire room. Unit may be recessed or surface-mounted. Alkco Manufacturing Co.

320. Decorating service

Interior decorating services of flooring company now available to pharmacies and hospitals planning remodeling projects. Custom design service includes floor plan and color scheme, suggested wall and wood trim colors, curtain and drapery materials, floorings, and decorative elements. Representative calls on hospital and forwards necessary information to company's bureau of interior decoration. Armstrong Cork Co.

321. Operating table

"Surg-A Matic" operating table features push-button selection panel located at end of right control arm. Enables operator to adjust table quickly and easily to operative positions. Table features single adjustment proctoscopic position. Table height adjustments range from 27 in. to 45 in., with maximum flex position of 139°. Available with two types of hydraulic bases—motorized, or non-motorized operated by foot pedal. Motor completely concealed in mechanized base. Shampaine Co.



322. Disposable razor

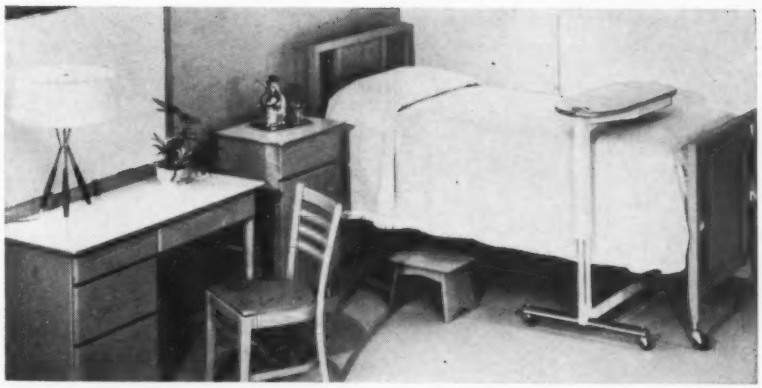
Disposable, precision-made safety razor has built-in blade, is individually sealed in moisture-proof package. Saves nursing staff's time in doing prep work. Sanitized packaging prevents cross infection. Loose blade hazard is eliminated. Conveniently packaged for wall or shelf in "Dispensa-Kit" containing 36 razors. Continental Hospital Industries, Inc.

323. Plate covers

Aluminum plate covers now available in 12 sizes which fit commercial plates from 8½ in. to 11⅜ in. Indented covers permit stacking which saves time and steps in serving. When not in use, covers nest. Mild soap and water maintains brilliant Golden Glow or Silver Glow finish. Wear-Ever Aluminum, Inc.

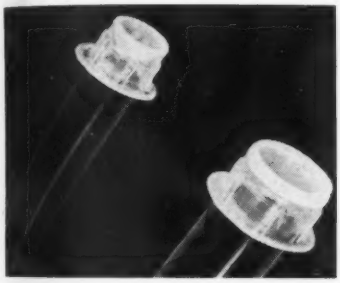
324. Furniture

Chieftain Oakline furniture is hand-crafted, sturdily constructed of high quality northern red oak. Natural wood grain and figured pattern gives attractive, warm appearance. Autumn gray finish blends with various colors and decors. Fiberesin tops are unaffected by alcohol, grease, burns. Chairs upholstered in elastic U.S. Naughahyde. American Hospital Supply Corp.



325. Disposable tube

Plastic disposable tube has positioned cap that seals tightly or can be left loose for aerobic culture work. Special styrene plastic with-



stands prolonged heating at over 80° C., is resistant to breakage. Has high surface tension, for good blood clot retraction. Suitable for centrifuging at moderate speeds. Delivered sterile. Falcon Plastic Products.

326. Mattress

Mattress made of Curon, multicellular foam, combines comfort with strength and wearability. Can be sterilized repeatedly without losing its soft texture, strength, or resiliency. Is flame-resistant, mildewproof, nonallergenic, non-toxic, will not support bacteria. Air-like construction makes it lightweight, easy to handle. Is completely reversible from top to bottom and side to side. Curtiss-Wright Corp.

327. Fire extinguisher

Dry chemical powder has been combined with fast action of pressurized, squeeze-lever construction in 2 new models of fire extinguishers, containing 20 and 30 pounds nontoxic, non-freezing powder each. Powder fans out in 60°-arc 15 or 20 feet to source of fire, turning into fire-killing gas. Fyr-Fyter Co.

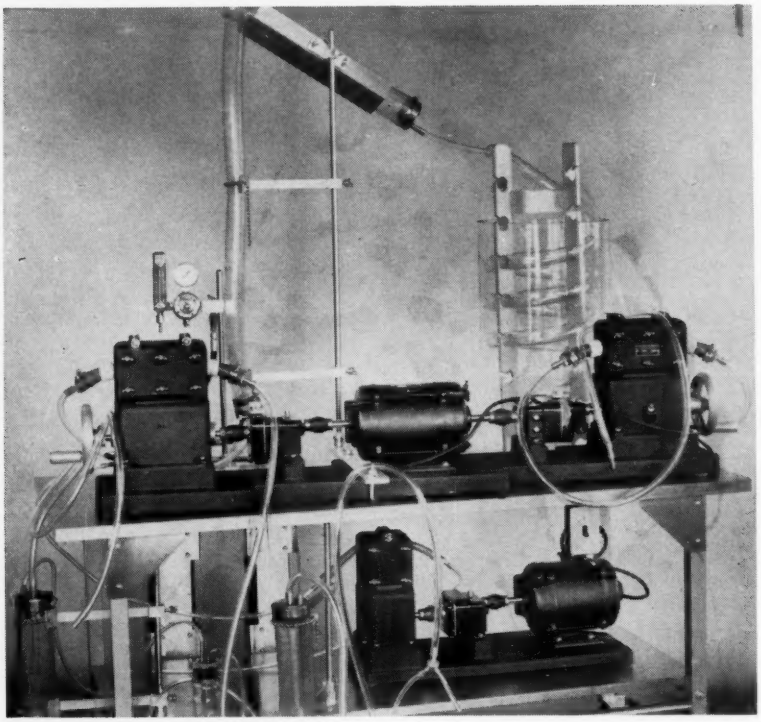
328. Paper tubing

SteriLine paper tubing has "built-in" indicator, is available in widths ranging from 1½ to 3 in. One-inch

markings aid in cutting tubing to desired length. Extra white space provided for noting date and description of autoclaved item. Can be used for catheters, syringes, pipettes, instruments, and larger items. Opens from either end, permitting easy insertion and removal of items. Aseptic-Thermo Indicator Co.

329. Cart cover

Plastic cart covers allow loads to be seen without removing cover, keep dust and dampness out while cart is not in use. Waterproof and greaseproof, washable. Seams stitched with heavy-duty thread. Folds compactly. Comes in 2 sizes to fit most carts. Can be used in auxiliary gift shops, food service, library service. Samaritan Cart Co., Inc.

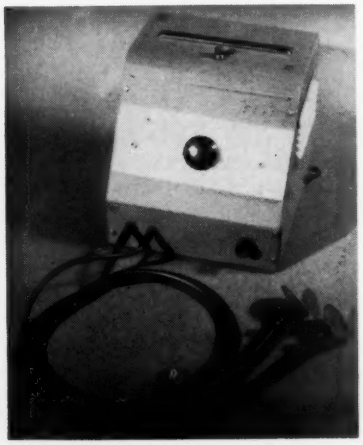


330. Blood oxygenator

Helix reservoir bubble oxygenator is used for cardiopulmonary by-pass during open heart surgery. Maximum conservation of blood is provided because size of apparatus is easily altered depending upon size of patient. Blood can be delivered to patient in any quantity necessary to maintain adequate blood pressure during perfusion and normal electroencephalograms. All surfaces in contact with blood are autoclavable. Cost within reach of any size hospital. Phelan Manufacturing Corp.

331. Cardiac defibrillator

Low-cost cardiac defibrillator is simple in design and construction. Operates on 110-volt, 60-cycle alternating current. Leads and electrodes withstand normal autoclaving. Herbert D. Klein.



332. Fast-setting plaster

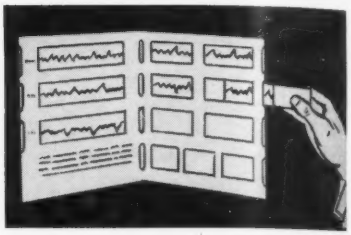
Pressona Hard-Coate plaster of Paris bandages and splints set in 2 to 4 minutes, because of gypsum impregnation. Medical Fabrics Co.

333. Oxygen rebreather

"Dalanator," lightweight oxygen rebreather, can be used as standby for emergencies in therapy and laboratory rooms not normally equipped with piped oxygen or conventional inhalators, or en route from emergency entrance to bed. Uses thumb-sized metal capsules of oxygen discharged, as needed, into accordion pleated breather bag of tough, elastic siliconvinyl. Bag is attached to mask assembly which contains chemical filter that traps carbon dioxide during rebreathing process. Operation is simple and safe. Total weight of unit is 3 lbs. The Palmer Co.

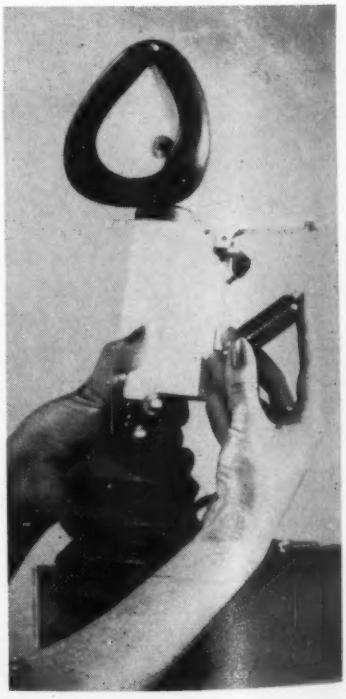
334. EKG mounts

Complete line of cardiographic mounts now available in two styles, folder and card. Come in 12 leads for all makes and sizes of electrocardiographic films. Made of durable stock to withstand handling. Low in cost. Robert Whitehill, Inc.



335. Blood-pack

Plastic blood handling equipment provides exclusive integral donor tube for closed system collection. Serially numbered tubes provide safe method for typing, cross-matching and culturing. Positive tamper-proof identification. Blood components readily removed aseptically for specific therapeutic use by means of exclusive double sterile outlet ports. Special hemorepellent surface of Blood-Pack unit and laminar flow needle reduce clotting, sludging, hemolysis. Fenwal Laboratories.



336. Oxygen cylinder

Model LC-3 cylinder converts liquid oxygen to gas before it is delivered to patient. Provides convenience, safety, and economy in administering oxygen by tent in hospitals without piping systems. Holds equivalent of more than 12 standard cylinders, 4- to 5-day supply. Will not tip over easily, does not contain gas under high pressure. Linde Co., division of Union Carbide Corp.

337. Test tube basket

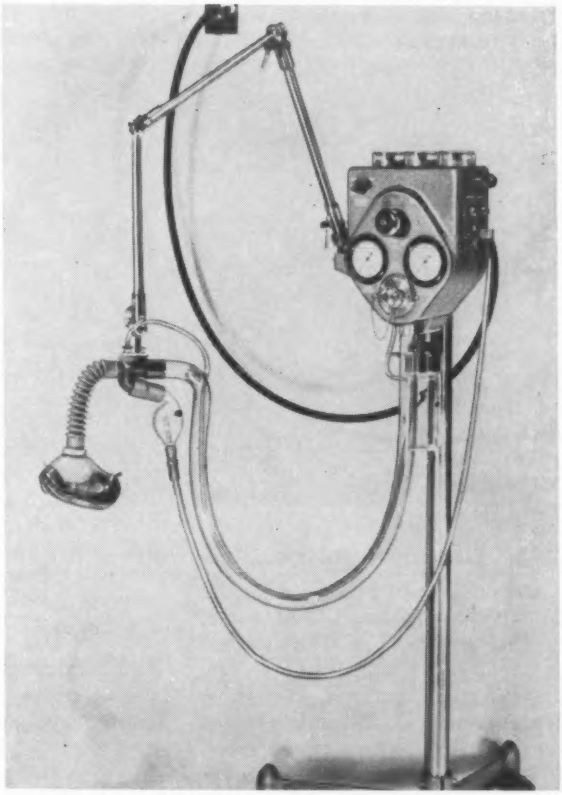
Rust-free stainless steel test tube basket is sturdy, with welded joints. Edges are rounded to secure more efficient drainage. Basket has floors to accommodate smallest sizes of glassware. Available in five sizes, ranging from 4″ x 4″ x 4″ to 10″ x 6″ x 6″. Aloe Scientific, division of A. S. Aloe Co.

338. Needle holder jaw

"Kant-Slip" jaw inserts for needle holders are made of special alloy steel which will not rust or corrode. Will withstand extreme pressure and abrasian. Needles may be used many times. H. F. Bramstedt Instrument Service Co.

339. Radiation meter

Portable, battery-operated survey meter measures intensity of, and distinguishes between, alpha, beta, and gamma radiation. Protects personnel from danger of over-exposure to radiation from x-rays. Has removable battery pack, easily replaceable alpha screen, large, easy-to-read meter face, hard-chrome plated aluminum case. Suitable where high degree of accuracy is desired. Technical Associates.



340. Respiration unit

Bennett PR-1A respiration unit now available for hospital use in therapy, resuscitation, or respiratory assistance. By simple setting of automatic cycling rate control, unit maintains or insures respiration when used as a resuscitator or respirator. Cycling mechanism does not interfere with activation of the valve by normal respiratory effort. During automatic operation, patient can begin own breathing pattern without being blocked or restricted. Respirator will again cycle automatically if the patient stops breathing or slows down to below the set cycling rate. Features include adjustable aspirator, air/oxygen diluter, and large nebulizer for long term use. Bennett Respiration Products, Inc.

FILMS, New Literature

341. Centrifuge models

Two-color brochure provides easy-to-use guide containing specifications and features of more than 20 different models and combinations of table type centrifuges. Descriptions of all available accessory equipment are also given, as well as performance data, capacity, and details required for selection of centrifuge model best suited for each job. Clay-Adams, Inc.

342. Quantity recipes

Packet contains over 50 recipes featuring volume meals with skinless frankfurters, smoked links, and luncheon meats. Suggestions are offered for supplying proteins in institutional meals at low cost. Quantities are flexible, to include both small and large institutions. Visking Co., division of Union Carbide Corp.

343. X-ray equipment

Catalog of x-ray accessories, isotope and inspection equipment, radiation protection and film processing equipment is now available. Photographs, illustrations, diagrammatic drawings, specifications, and product information included in 56-page brochure. Bar-Ray Products, Inc.

344. Fire extinguishers

Chart on *How to Select a Fire Extinguisher* is designed to keep pace with recent research developments in portable fire extinguishers. Reference guide outlines the three basic classes of fires, lists seven types of portable fire extinguishers. Printed in two colors on heavy 8½" x 11" paper. Fire Equipment Manufacturers' Association, Inc.

345. Oxygen piping

Hospital oxygen piping service—from planning the system to supplying the patient—is described in new *Hospital Piping Equipment* catalog. Designed to help in planning complete or partial oxygen therapy service for either new or existing buildings, catalog tells of available services such as preparation of piping layouts, data sheets and specifications, and equipment and installation information. National Cylinder Gas Co.

346. Pharmacy career

Booklet titled *Your Career Opportunities in Pharmacy* has been prepared to help offset shortage of trained pharmacists. Tells graphically how young people can become members of nation's health team—in hospital, retail, or industrial pharmacies. Charles Pfizer & Co., Inc.

347. Ultrasonic cleaners

First mass-produced line of high capacity, production-size ultrasonic cleaners is described in Data Sheet No. 600. Sheet contains photographs and technical information on low-cost ultrasonic equipment, including Narda SonBlaster ultrasonic transducer models NT-601 to NT-609. Narda Ultrasonics Corp.

348. Vitamin deficiency

Why the '40-plus' Patient Needs More Vitamins gives factors most frequently affecting the aged which reduce intake, limit absorption, or increase need for vitamins. Booklet details how each system of the body may be affected by vitamin deficiencies. Merck & Co., Inc.

349. Plastic dressing

New 16 mm. sound film in color demonstrates technic of using plastic protective surgical dressing. Specially prepared by Stanley P. Rigler, M.D., and W. E. Adams, M.D., department of surgery, University of Chicago, for viewing by professional groups. Running time is 15 minutes. Aeroplast Corp.

350. Emergency lighting

New battery-powered emergency lighting system for hospital operating rooms is described in brochure. System, known as Castle No. 582, prevents surgical "blackout" by instantaneously switching illuminating power to battery in the event of power failure. Wilmot Castle Co.

351. Haemo-Sol report

Eight-page report presents technical data on Haemo-Sol, cleanser specifically formulated to produce chemically clean instruments and glassware. The results of 3 years of research include discussion of wetting efficiency, pH and buffer capacity, chelating action, solubilization, haemo digestion, and pyrogen removal. Meinecke & Co.

352. Sterilization film

A revised version of the sound color film, "Pressure Steam Sterilization," covers gas or "cold" sterilization as well as ultrasonic cleaning. The film runs 25 minutes and is available for showing before hospital, nursing, and other technical groups. It was produced for the committee on visual instruction, Society of American Bacteriologists. American Sterilizer Co.

353. Housekeeping film

Easy Does It is sound-color film for hospital housekeeping personnel. Film runs 20 minutes and is based on survey made of administrators and housekeeping supervisors. Topics covered include training and motivating capable personnel, observing safety procedures in maintenance, caring for equipment, and reducing time and effort expended in housekeeping. National Sanitary Supply Association.

354. Oxygen equipment

Oxygen therapy and respiratory equipment is described in revised catalog No. 10, an illustrated 27-page booklet. Oxygen tents and canopies, face masks, nebulators, humidifiers, and resuscitators are described. O.E.M. Corp.

355. Suture package

Clinical evaluation of new suture package has been released. Current methods of suture packaging, as well as the new foil package, are discussed. Results of the evaluation are given, with conclusions based on comments made by operating room nurses. Ethicon, Inc.

356. Refractometer data

Bulletin describing Aminco-Jonnard Refractometer, new instrument which measures refractive index differences, is now available. Gives detailed information on instrument's applications, operating principles, internal design, and complete ordering data. American Instrument Co., Inc.

357. Rhinoplasty film

Film portrays pre- and postoperative management as well as surgical procedures used in rhinoplasties. *Elective Rhinoplasty* is standard 16 mm. sound-color film, with approximately 28 min. running time. Schering Corp.

From the Hospital Meetings...

Above: Robert Moss (l.), administrator, Doctors Hospital, Cleveland, and Mrs. Moss, stopped in to see new items displayed at the booth of the Rehabilitation Division of American Hospital Supply Corp., at Tri-State Hospital Assembly. John Johns explains the operation of the Tomac diathermy unit, designed to produce electrical current oscillation. Approved by FCC and UL, it contains a high grade vacuum condenser which is not affected by moisture, vibration or other room conditions. Wide range parallel tuned output circuit permits quick, easy, and effective treatment of any body area. Condenser pad electrodes are applied rapidly and conveniently. C-360.

Above: EvenView Television Systems, division of Peter Even Enterprises, exhibited at the Association of Western Hospitals meeting recently. On hand to show the system to hospital personnel were (l. to r.): Jordan Beyer, San Francisco, divisional manager, Peter J. Even, president, and Edward Schmidt, Jr., vice-president, both of Beverly Hills, Calif. A remote control unit enables patient to turn set on and off and change channels; pillow speakers eliminate disturbance to other patients. No investment is necessary on the part of the hospital and income is derived immediately from the system. C-363.

Below: Rhodes Alderson (c.), sales manager, Parenteral Products division, Mead Johnson and Co., answers a question for Mrs. Ruth Stock (l.), assistant director of nurses, and Sue Nelson, central supply room supervisor, both of Mercy Hospital, Miami, at the Southeastern Hospital Conference at Miami Beach. They are inspecting a new plastic coupler which fits between the solution flask and the conventional infusion set, reducing drop size from 30/cc. to 60/cc. by means of a stainless steel insert in the drip chamber. This is valuable in instances of carefully controlled infusions, necessary in pediatric and cardiac patients. C-361.

Below: Also at the Southeastern conference wefe these Atlanta, Ga., hospital administrators, Edward Fisk (center), Crawford Long Hospital, and George Burt (r.), Piedmont Hospital. William R. Cooksey, American Laundry Machinery Co., explains laundry formula chart, adaptable for new or existing units. Operating times for various phases of the laundry cycle are punched on the card and the chart is fitted to a rotating copper drum which makes contact with electrical selectors. Intervals possible range from 20 seconds to 85 minutes. C-362.

Pediatrics

Illustrated Mats Cheer Children at Mealtime

A NEW SLANT on the ever-present problem of persuading hospitalized children to eat is the use of gaily-illustrated paper place mats on their food trays.

Authorities on child care as well as hospital personnel agree that there is "no perfect way to handle the business of taking a child to a hospital." In addition to feeling ill, the child is alarmed at being forced to leave his home and stay in a strange place, particularly one in which the routine and atmosphere are alien to what he understands.

Part of his anxiety is likely to show up in tension at mealtimes, when not only the environment but the experience of eating in bed is different from what he is used to at home. A number of hospitals have found that the place mats, decorated with subjects appealing to children, can do much to ease this tension.

If the mat's illustration tells a story, it only takes a word or two from the nurse at serving time to divert the child's mind to a pleasant, interesting train of thought which will continue after the nurse has gone on to the next patient.

A variety of illustrations can be stocked so that the child does not receive the same mat at every meal. However, repeating the use of a particular illustration after a few days may make it even more effective, since children like returning to the familiar, as well as having variety.

Hospitals already using these printed mats have discovered a few signposts in choosing material for illustrations.

Pictures of figures well-known to children, for example, tend to ease their minds and reduce anxiety. Television personalities are a natural subject since the child associates TV with his own home. Another advantage is that a single television figure is usually of interest to a wide range of age groups.

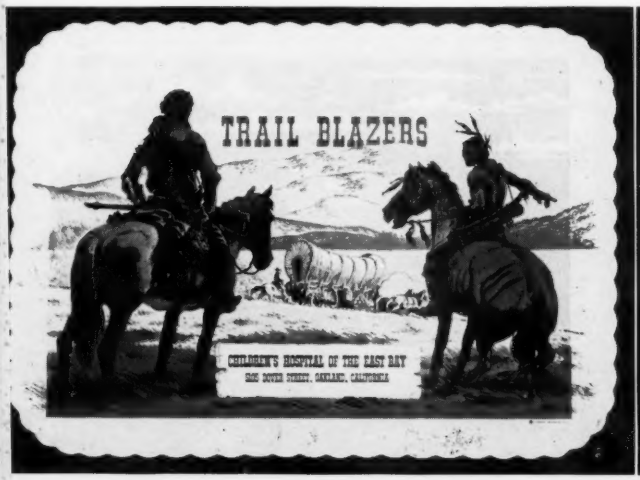
Well-loved characters from fairy tales and other children's stories are also useful. For older children, educational material can be utilized. Puzzles to be worked out entertain children who have reached the reading and writing age. Prints depicting historical events in a dramatic way hold the interest of school children who have studied the events.

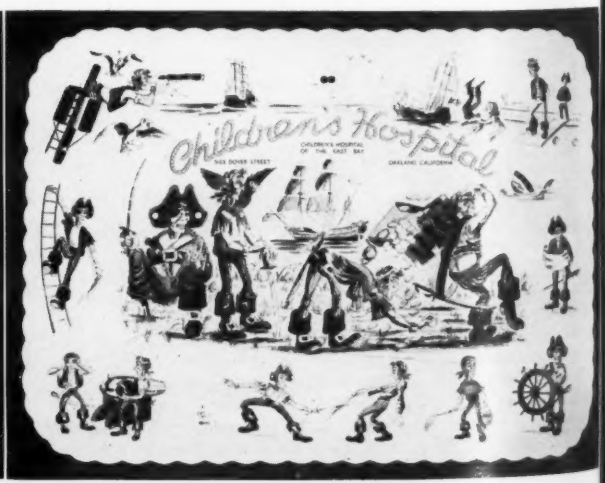
Hospitals have found that it's not at all necessary to restrict illustrations to recognizable personalities. Many use mats picturing typical western scenes, collections of toys, and other subjects familiar to a child.

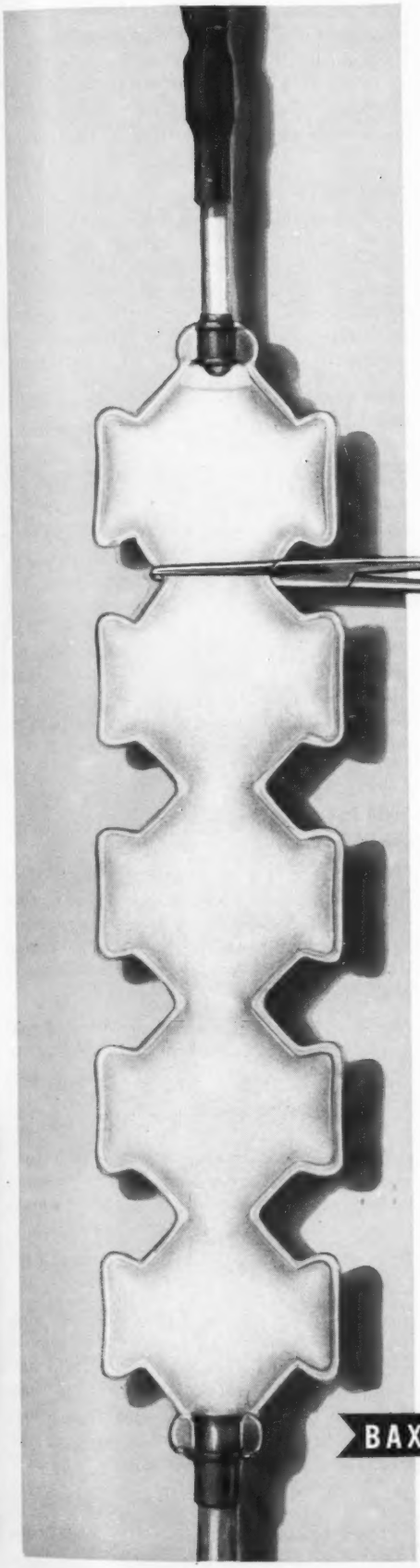
At Children's Hospital of the East Bay, Oakland, Calif., for instance, younger children favor a cartoon-like scene of a western corral. Featuring plenty of action, the print includes bucking broncos, steers, cowboys roping and riding, and other items youngsters associate with the West. For the older group, there is a more formal view of covered wagon days, showing a typical scene of settlers moving westward.

Another successful mat used by this hospital is a colorful pirate scene complete with swordplay, buried treasure, ships, cannon, and the regulation eye-patches standard for children's pirates. The younger set enjoys a mat picturing a group of toys including animals, blocks, firemen, and policemen, with a jack-in-the-box overlooking the collection.

(Continued on page 76)

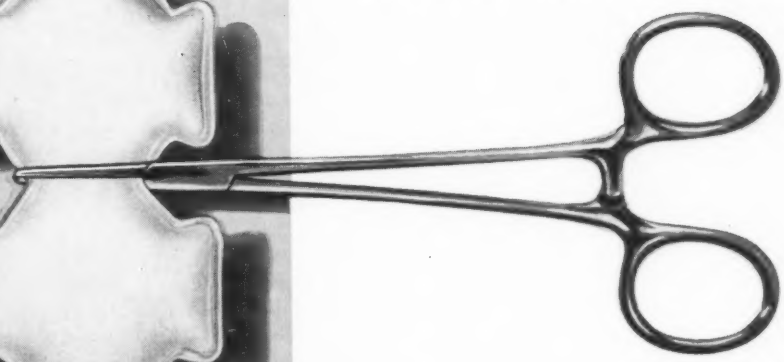






New concept in PEDIATRIC *dosage control*

R36 PEDATROL*



New and radical in design, the segmented chamber of PEDATROL permits exact control of solution or blood administration, from 10 ml. to 50 ml., in increments of 10 ml.

Each compartment of the chamber holds precisely 10 ml. of fluid. By clamping off at any point between compartments you automatically set up the required dosage. Simple, efficient and accurate . . . without constant supervision. Once the hemostat is clamped, only the prescribed contents can be administered. Flashball® above top segment simplifies supplemental medication.

Make PEDATROL standard equipment in your Central Supply. Save nursing time . . . ease the work load . . . surely, safely, economically.

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DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH
AMERICAN HOSPITAL SUPPLY CORPORATION
SCIENTIFIC PRODUCTS DIVISION GENERAL OFFICES • EVANSTON, ILLINOIS

Absorbed in colorfully illustrated story on food tray, hospitalized child eats nourishing meal without feeling tense and anxious in strange environment.

PEDIATRICS

(Continued from page 74)

In addition to having value as morale-boosters, these mats have a practical side. They assure a sanitary serving surface at low cost and avoid the laundering of extra linen.

In a recent survey of 300 hospital dietitians, the Paper Cup and Container Institute found that 76.3 percent of the institutions responding used paper place mats and tray covers for the service of regular diet meals. Appropriately decorated, these mats can add interest and variety to hospital meals for children and adults as well.

Emotional Stress in Child May Affect Recovery From Surgery

Successful recovery from surgery is often related to internal emotional stresses, state Francis and Cutler.* Children between the ages of two and one-half and seven, and from prepuberty to early adulthood are undergoing physical and emotional changes which are not readily compatible with the emotional trauma of surgery and/or anesthesia they point out. A child's ability to reason is limited and his approach to life is literal; hence, the authors recommend, surgery should be explained simply and without the use of abstractions and analogies. Surgical events should be described in terms which will not stimulate the child's imagination or cause alarm. The adolescent, they add, must be assured that the physician is sensitive to his peculiar problems.

Parents should be counseled in easily understandable terms and made familiar with the scope, duration, and probable course of recovery of surgery, according to the authors. In making explanations to the child-patient, parents should be encouraged to tell the truth to the inquisitive child. But they should answer only the questions asked and volunteer no information beyond this point, the writers add.

The child's misconceptions should be corrected in simple language, they continue. Parents' anxiety will radiate to a child and influence his healing process, so it is essential that they be reassured often and well.

Postoperatively, the child should be encouraged to verbalize, so that his fears will be expressed and erroneous ideas can be corrected to avoid future neuroses, the authors note. Psychiatric treatment preoperatively is important if the child exhibits any symptoms of neurosis or if he has suffered unusual traumatic experiences in the past, they say. The child who has experienced recent emotional trauma, they add, should be given therapy before an elective operative procedure; injectable drugs should be abandoned in favor of oral administration, whenever possible.

*Francis, Lewis, M.D., and Cutler, Robert P., M.D.: Psychological Preparation and Premedication for Pediatric Anesthesia. *Anesthesiology* 18:106 (January-February, 1957).

MEMO TO:

THE SURGICAL STAFF

Been harassed by staph spreading through your hospital? Now you can suggest a practical way to strengthen routine control.

Turn to page 37

Study Finds Infants Thrive On Cold Milk Formulas

Of 150 infants in his private practice who were changed gradually from warm milk formulas to cool or cold bottles, Gibson* found that 89 percent accepted the unheated milk within an average period of one week. The infants ranged from 15 hours to seven months.

The author found that the acceptance rate of cold formulas varied from about 50 percent (23 of 43 babies) for the very young infants to about 75 percent (28 of 39) in the older group. A total of 134 infants in the series accepted cool or cold formulas.

A cool formula, the author considered to be one removed from the refrigerator and allowed to stand until it reached room temperature; a cold formula was one taken directly from the refrigerator.

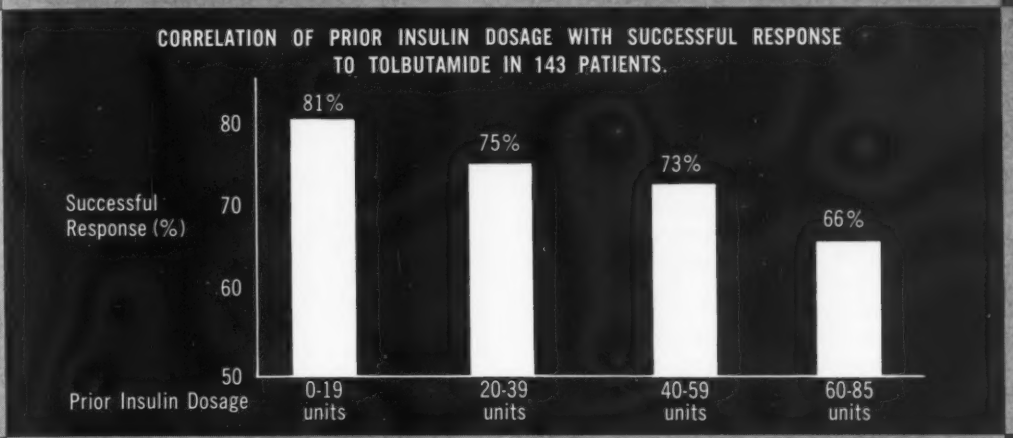
None of the infants showed any weight loss and the author observed no harmful effects from the change.

One mother, after the delivery of her second baby, requested that he be trained to take a cold formula in the hospital nursery because her first child had done so well on that type of feeding. The infant had received one warm bottle, which he took well, when he was 12 hours old. At the age of 15 hours he was given two ounces of ice-cold formula which he also took well and without ill effects.

*Gibson, John P., M.D.: Reaction of 150 Infants to Cold Formulas. The Journal of Pediatrics, 53:404-406 (April, 1958)

AN AMES CLINIQUICK

CLINICAL BRIEFS FOR MODERN PRACTICE



can selected diabetics on insulin be changed over to tolbutamide on an ambulatory or outpatient basis?

Yes. By gradually reducing insulin dosage during the change-over and by frequent daily testing of the urine—by the patient—for sugar and ketone bodies.

Source—Sugar, S. J. N.: Ann. New York Acad. Sc. *71*:256 (July 10) 1957.

for the change-over from insulin

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the STANDARDIZED urine-sugar test for reliable quantitative estimations ...standard "plus" system...standard blue-to-orange spectrum

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ACETEST® BRAND Reagent Tablets—rapid, reliable test for ketonuria

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OB DEPARTMENT

Georgia Institutes Stress Understanding in Nursing Care

By Marian F. Cadwallader, M.P.H., M.A.C.N.M.*

• An article in the February, 1958, issue of HOSPITAL TOPICS described the planning, program content, and immediate evaluation of five one-day institutes on the hospital care of mothers and newborn infants, held in five hospital council areas in Georgia in 1957. These institutes were sponsored by the Georgia Hospital Association, the Interdivisional Committee on Maternal and Child Health of the Georgia State League for Nursing, and the Divisions of Hospital Services and Maternal and Child Health of the Georgia Department of Public Health.

In this article, an attempt will be made to give, in more detail, some of the program content. Unless otherwise indicated, the material which follows is a composite of talks presented by different persons who appeared on the institute programs.

Nursing Care During Labor and Delivery

At four of the five institutes, "Nursing Care During Labor and the Immediate Postpartal Period" was presented by Ruth Melber, who was, at that time, obstetrical supervisor at Emory University Hospital, Atlanta. At the fifth institute, Sister M. Graziana, R.S.M., St. Joseph's Hospital, Savannah, and a panel of local hospital nurses presented this topic.

Included in these presentations were some recommendations for antepartal nursing care, with special reference to the emotional problems of the woman who must be hospitalized during the antepartal period because of threatened or inevitable abortion or because of other complications.

Self-centered feelings of depression, fear, anxiety, rejection, and guilt, normal during the first trimester, may be heightened by the possibility of interruption of the pregnancy. During the second trimester, after quickening has been experienced and feelings are apt to be more baby-centered, the same emotions may be carried over to a greater or lesser degree or they may be replaced by feelings of fulfillment and satisfaction. During the third trimester, because of approaching delivery, anxiety and dependence may be increased.

Complications during this time, whether they end in premature delivery or not, may result in additional depression, fear, and guilt feelings for the expectant mother. Nurses should recognize the emotional problems of women hospitalized because of complications prior to delivery and should make an effort to adjust their personal contacts with these patients accordingly.

Antepartal classes for expectant mothers or, preferably, for both mothers and fathers, have many advantages and there is a need for more such instruction. All nurses should know when and where such classes are offered in their community. If classes are not offered nurses should give thought to how such a need might be met. Recognition should be given to parents who have attended such classes. Some observant nurses have been able to tell that the mother and father have attended classes from their reactions during labor.

The historical background of hospital delivery was discussed briefly at the institutes. Formerly hospitals were not considered safe places for women to have babies. In recent decades, safety has been greatly increased by advances in medical knowledge, and by establishment of rules and regulations set up specifically to safeguard mothers and babies. Now, however, some of these very advances have turned out occasionally to be disadvantages. These include such problems as morbidity from staphylococcal infections, sensitivity to antibiotics, and reactions to blood transfusions and to anesthesia. Anesthetic accidents are now a statistically important cause of maternal death. In addition, thrush, impetigo, and diarrhea take their toll of newborns in crowded nurseries.

One result of establishing the many rules and regulations is that having a baby is no longer a family affair. This change has become increasingly important as the significance of satisfactory, early mother-child-father relationships has been recognized. Regimented care does not appear to contribute to family growth and development. All health personnel need an appreciation of what the whole family gives to and derives from pregnancy and childbirth. Also, for many women, the time of delivery is their first experience with hospitalization. Situations and even words, customary to hospital personnel, may be extremely fear-provoking to the uninitiated. Many expectant mothers and their families welcome assurance that spiritual as well as physical needs will be met.

NURSING FUNCTIONS DURING LABOR

The nursing function most readily accepted by the woman in labor is bodily care. Perhaps less readily accepted is the idea that the nurse might provide a

*Consultant nurse, Division of Maternal and Child Health, Georgia Department of Public Health, Atlanta.

listening ear, and even diversion early in labor.

Baths, preps, enemas, back rubs, maintenance of cleanliness of the patient and the bed are expected duties of the nurse. However, if the nurse explains orders and procedures before she carries them out, it will help the mother in labor feel less like an object to whom strange things are done without her consent.

The nurse must check the fetal heartbeat at regular intervals, and make such other examinations to judge the progress of labor as are customarily delegated to nurses in her particular hospital. The progress of labor can be gauged even without making a rectal examination, which not all nurses are prepared to do. Indications of progress in labor, such as an increase in the frequency, duration, and intensity of contractions, increasing backache, more show, rupture of the membranes, and pressure sensations around the rectum, all can be observed by anyone who knows what to watch for.

HUSBAND SHOULD BE INFORMED

The mother should know whenever reports about her progress have been made to her husband. And the husband who is not with his wife should be given information at least every half hour.

The patient in labor needs relief from discomfort as well as pain. Nursing measures which will increase her comfort are back rubs, changes of position, administration of fluids and opportunity to void. The mother may have less pain and thus require less sedation, if with her she can have her husband or another person to whom she feels close.

This need of the woman in labor to be sustained by another human being cannot be overstressed. If the nurse is too busy for this important task, an aide, a practical nurse, even the husband, although customarily he is banished to pace the floor in the waiting room, should be assigned to this duty. No woman should be completely isolated during labor. If she is under heavy sedation, she needs nursing care at all times. If she is not heavily sedated, she needs constant encouragement, information concerning her progress, reassurance about her ability to have a baby, and as much assurance as possible that the outcome will be safe and successful for herself and her baby. Since the mother often misses the actual miracle of birth, she should know that baptism will be provided for the baby if necessary.

Of course, in some instances, it is absolutely impossible for the woman in labor to have someone with her constantly. Under these circumstances, the nurse can ease the situation for the patient by explaining why she has to leave, where she is going, when she will be back, and how she may be summoned if she is needed.

The mother needs to have attendants accept her personal attitudes toward, and behavior during, labor. What happens during labor in the way of bizarre behavior or talking must be held in confidence by the nurse and not repeated to the mother or to other members of the family.

Nursing functions in the delivery room include giving assistance to the doctor and the anesthetist, encouraging the conscious mother, caring for the baby, preparing the mother for return to her own room or to the recovery room, and planning for the father to see his wife and baby as soon as possible. Conversation among the attendants during the delivery should be limited to that required by the situation, and discretion should be used in what is said. Even apparently anesthetized patients may still hear the spoken word and be disturbed by it. Professional nursing time will be used more effectively if the nurse does not scrub for the delivery, since scrubbing is a technical procedure which can be performed just as well by other personnel.

When the nurse cares for the baby, she must see that its airway is clear, that respiration is maintained, and that warmth is provided. She will usually be the one to instill the eye drops, and place the identification on the baby. When the mother is awake, the nurse will show her the baby, and let her hold it if she wants to do so. Often the nurse will notify the husband that the baby has been born and will let him and other members of the family see the baby before it goes to the nursery.

Because physicians cannot always arrive at the hospital in time to attend a birth, the nurse must know how to deliver a baby safely in an emergency situation. Holding the baby back in any way, except for control of the head during birth, is dangerous.

IMMEDIATE POSTPARTAL NURSING CARE

The newly delivered mother should be kept in the delivery room or in a recovery room until she is awake and can answer questions. During this time, her fundus should be checked at regular, frequent intervals; temperature, pulse, respiration, and blood pressure should be taken; and amount of lochia noted. All information obtained should be recorded on the mother's chart. Abnormal findings should be reported promptly. The mother's questions should be answered. She should then see her baby, if she has not already done so, and her husband as soon as it can be managed.

At one of the institutes, many of the nurses expressed great interest in natural childbirth and its implications. Some of the nurses had had experience with this method, others were interested because of what they had read. Considerable discussion centered around the fact that many physicians give sedation routinely at 4 cm. dilatation, and that preparation of the expectant mother to participate actively in her own delivery requires more time than is available to the physician in advance of delivery.

It was pointed out that a prepared nurse can help an otherwise unprepared mother to relax during her contractions, even during labor, and that even sedated mothers are still accessible to a greater or lesser degree of coaching.

Continuous Nursing Care of the Mother

Talks at the institutes on continuous nursing care stressed meeting the postpartal needs of the mother in the hospital. Discussion included: technics of breast

(Continued on next page)

and perineal care; advantages of nursing; methods of encouraging and assisting women who wish to breast feed their babies; adequate nutrition; the need for all families—especially those having their first babies—to have some acquaintance with the infant before taking it home; and the possibility of referral of selected mothers for public health nursing care in the home.

For many mothers, the short time in the hospital after delivery does not give them enough opportunity to learn what they need to know about caring for themselves and their babies. Because of this short hospital stay, the technics of care used for the mother should be simple and easy for her to transfer to home use. Each nursing contact should be used to increase the mother's knowledge and her feelings of security in her own ability.

The criteria for evaluation of nursing procedures in care of the mother include these: safety; comfort; economy of time, effort and material; effectiveness, and finish or appearance. These factors apply to both breast and perineal care, as shown in Figure 1.

The goals of safety are prevention of cross-infection, self-infection, or infection of the infant; and non-interference with the body's own protective mechanisms. To prevent cross-infection, individual equipment is needed for each mother for breast and perineal care. It is recommended that pitchers of solution and containers of pads and cotton balls not be used in common by, or for, many mothers.

To prevent self-infection or infection of the baby, the breasts should be washed before the rest of the bath is given, and the mother must be given handwashing facilities before each nursing.

In perineal care, gentleness in wiping and a front to back motion should be stressed to the mother. Routine use of antiseptic solutions is not recommended because the mother may then have a false sense of security; also, such solutions may interfere with the body's own protective mechanisms. It is doubtful that such solutions are in contact with the skin for a sufficiently long period to be effective; the presence of body secretions will interfere with the antiseptic action; and, finally, some very popular antiseptics are ineffective when used on skin to which soap has previously been applied.

Comfort is increased by the cleanliness resulting from proper breast and perineal care. Support for the breasts, and the use of non-irritating sponges and solutions for perineal care will enhance the mother's comfort during her hospital stay.

Breast care need be carried out only once a day, and, to provide economy of the nurse's time, may be done after instruction, by the mother, when she takes her bath in the morning. The nurse will need to give the necessary perineal care until the patient is ambulatory; possibly thereafter, the nurse need give the care only after defecation. Each mother should be instructed in the proper technic of perineal care.

To achieve economy of nursing effort, the mother should be given handwashing facilities before each nursing. As mentioned, with instruction, she can be responsible for her own perineal care when she has bathroom and/or shower privileges. Handwashing facilities for the mother before nursing seem to be particularly difficult to provide. Many hospitals customarily give the mother a gauze sponge moistened with an antiseptic solution with which she wipes her hands before handling the baby or her breasts. It seems doubtful that the antiseptic solution is in contact with the hands long enough to be effective.

An economical choice of material will give the mother a clean washcloth and the usual bath equipment, and a clean face towel for covering the breasts or a clean nursing bra. Equipment for perineal care includes individual packages of sterile tissue wipes, and individually-wrapped, sterile, perineal pads, or pads and cotton balls wrapped together for the mother who is ambulatory. If individual perineal trays are used, they should be stocked with tap water in a covered pitcher, a can of pads and cotton balls wrapped and sterilized together, and paper bags or other containers for disposal of used cotton balls and pads. Some hospitals are finding that a clean technic for perineal care is as satisfactory as a partially sterile technic.

It is felt that simple, individualized technics for both breast and perineal care provide the greatest effectiveness in nursing procedure. Such technics are safe and comfortable, they are economical of nursing time, effort and material, and a properly instructed mother can easily transfer them to home use.

A contented, comfortable mother, showing evidence of progressive healing is the criterion used to judge finish and/or appearance of the nursing procedure.

General Considerations

During discussions of nutrition at the institutes, questions posed were: Are the hospital's meals always supplying recommended foods, especially to nursing mothers? Are these mothers being told of the importance of their own nutrition to successful breast feeding of their infants?

Recognition was also given at the meetings to the

MEMO TO:

O.R. SUPERVISOR

Thorough, thorough, thorough--
that's the way you want the O.R.
cleaning and disinfecting to be,
isn't it? Now it can be in less
time at less cost with less effort.

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"postpartum blues." The feeling was expressed that such moods might be a natural reaction to the general letdown after delivery, or might arise perhaps from disappointment over the sex or appearance of the baby. Perhaps the mother feels fear about taking on additional responsibilities, or doubts her capabilities of being a good mother.

Not all women experience a maternal feeling as soon as they have had the baby. This may cause considerable anxiety. Sometimes the explanation that maternal feelings are slow to come helps to alleviate anxiety.

Various methods of teaching parents even during a short hospital stay were discussed. Rooming-in, either modified or complete, is considered valuable for this purpose. Bathing the baby in the mother's room, at a time when the father is present, then allowing either one of the parents to give the bath under supervision the next time, is helpful. Observation of the mother and baby during nursing, either by breast or by bottle, will indicate areas in which the mother needs additional information. During this discussion, some emphasis was put on the fact that all the nurses in the obstetrical department, not only those in the nursery, might participate in this teaching. The nurses usually enjoy such activity.

Public health nurses who participated in the institutes were most interested in learning about the technics of care used in the various hospitals. As their contribution to the subject of continuing nursing care, they described the services available to all mothers through the state health department. The public health nurses had to stress the fact that they could not take all referrals routinely, even of staff cases, but would be happy to try to visit mothers who had particular needs for continuing nursing care, either for themselves or their babies.

Figure 1

Criteria for Evaluation of Nursing Procedures

Criteria	Breast Care	Perineal Care
Safety		
1. Prevents cross-infection	Individual equipment	Individual equipment
2. Prevents self-infection or infection of infant	Washing of breasts before rest of bath Handwashing facilities for mother	Front to back wiping, gentleness
3. Does not interfere with body's own protective mechanisms	No routine use of antiseptic solutions	No routine use of antiseptic solutions
Comfort	Cleanliness, support if needed	Cleanliness, use of non-irritating solutions and sponges
Economy		
1. Time	Needs to be done only once daily, mother may do after instruction	Will need to be done by nurse before patient is ambulatory, and possibly once a day or after defecation
2. Effort	Handwashing facilities for mother before each nursing	May be done by mother after instruction when she has bathroom and/or shower privileges
3. Material	Clean washcloth, usual bath equipment, clean face towel, or nursing bra	Individual packages of sterile tissue wipes, and individually wrapped sterile perineal pads, or pad and cotton balls together
	Individual breast trays may also include hand-cleansing facilities	Individual trays with all equipment to include: Tap water in pitcher Can of pads and cotton balls wrapped and sterilized together Paper bags and newspaper bags for disposal
Effectiveness	Safe, comfortable, does not interfere with body's own protective mechanisms, is easily transferred to home use	Safe, comfortable, does not interfere with body's own protective mechanisms, is easily transferred to home use
Finish or Appearance	Contented, comfortable patient	Contented, comfortable patient, progressive healing

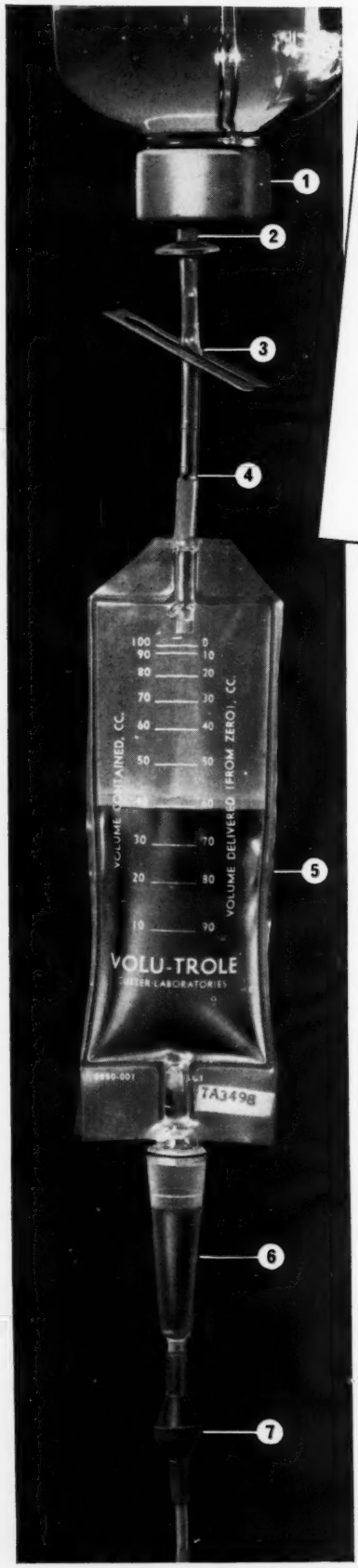

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Illustration

1. Dispensing Flask
2. Bottle Connector Spike
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HOSPITAL Topics OR

Official bulletin for the
Association of Operating Room Nurses

Staphylococcal Hospital Infections

The study of staphylococcal infections at Temple University Hospital, Philadelphia, has been one of the most discussed topics in the hospital field since its results were first announced last fall at the clinical congress of the American College of Surgeons (see HOSPITAL TOPICS, December, 1957, page 17). In this symposium, adapted from a panel discussion presented at the fifth national congress of the Association of Operating Room Nurses in Philadelphia, members of the committee which made the study at the Temple University School of Medicine and Hospital discuss their methods and findings, and nurses tell their role. The symposium is followed by selected questions from the discussion period.

Participants

H. TAYLOR CASWELL, M.D., clinical professor of surgery, moderator.

HOWARD H. STEEL, M.D., assistant professor of orthopedics.

KENNETH M. SCHRECK, M.D., assistant professor of microbiology.

FLORENCE E. BROWN, R.N., director of nurses.

ELSIE R. CARRINGTON, M.D., assistant professor of obstetrics and gynecology.

MILDRED L. GUZARA, R.N., operating room supervisor.

DR. CASWELL: When antibiotics first were introduced, few heeded the occasional voice which warned that some day organisms would develop which would be resistant to these wonder drugs. Unfortunately, the prediction has come true. Today the problem of staphylococcal infections in hospitals is worldwide — and nationwide, countywide, and townwide, also.

The study at Temple University was undertaken because we were faced with this problem. A committee was formed about two years ago. All infections occurring in the institution were investigated by this committee. Each committee member saw every patient with an infection, gathered the material and information, and brought it back to a committee meeting. The infection was then classified as to whether or not it was hospital-related.

Extensive bacteriologic studies were carried out on all isolated organisms by the department of microbiology under the direction of Dr. Schreck. In addition, all phases of technic throughout the institution were reviewed, and notable changes made. The committee also surveyed possible sources of contamination such as blankets, medical and surgical equipment, and other hospital articles, and developed a method of locating infections among hospital patients and personnel.

Resistant organisms have been reported as the source of infection, in our hospital and others, in a number of areas of major concern. The greatest number of such infections have been found in the following areas:

—Infections in clean surgical wounds, certainly one of the big problems.

—Cutaneous infections in newborn infants. Also in newborns, bacteremias, breast abcesses, and similar infections have been found.

—Breast abscesses in the postpartum period. We feel, as do others, that the mode of infection of the mother's breast is unquestionably via organisms present in the infant's nose and throat, which have been picked up in the hospital nursery.

(Continued on next page)

Dressing cart, used for changing dressings, is in charge of a trained surgical nurse. Cart comes from CSR department.

STAPH. INFECTIONS

—Staphylococcic pneumonia, a tragic complication which can occur in patients postoperatively and after influenza. With its overwhelmingly rapid course downhill, ending in death, it is an extremely dangerous threat.

—Cutaneous infections in nonsurgical hospital patients—medical patients who develop boils and carbuncles.

—Cutaneous infections in hospital personnel. There is no question that staphylococci from these cutaneous lesions can be passed to patients by infected personnel, and vice versa. Keeping nurses has become a real problem in some institutions because of the number that develop cutaneous infections such as boils and carbuncles.

One of the most important measures initiated by the committee, we think, was bacteriophage typing of organisms isolated from infections in our institution. Will you comment on this, Dr. Schreck?

DR. SCHRECK: First, let me review what a bacteriophage is and how it is used in typing staphylococci.

A bacteriophage is a virus which parasitizes specific bacteria. The procedure for typing is this: First the staphylococcus which has been isolated from a patient is grown in a broth culture; then the surface of the petri dish is heavily inoculated with the culture.

After the mass inoculum has been put on the surface of the dish, a drop of each given bacteriophage is put in its appropriate square in the grid. For instance, in the 3A grid area is put one drop of 3A bacteriophage; in the 3C square a drop of 3C bacteriophage is placed. After a drop of each of the 25 different bacteriophages has been applied, the plate is incubated overnight. In the morning, the plate is checked for areas in which a bacteriophage has attacked and lysed the bacteria.

For example, in one strain of *Staphylococcus aureus* isolated from a patient, evidence of lysis was apparent in squares 42B, 52, and 81. From this we have the best name that can be found for this organism, that is, 42B/52/81.

This strain, 42B/52/81, is the *Staphylococcus aureus* which has accounted for the vast majority of our hospital-related infections and which has been reported now from many states in this country, and also from Canada, Australia, and Germany.

DR. CASWELL: Bacteriophage typing in our study revealed these facts:

In clean surgical wounds, of 136 infections, 48 percent were of bacteriophage type 42B/52/81.

In 28 cases of infected traumatic wounds, burns, and other dirty surgical wounds, 53 percent were 42B/52/81.

Of eight cases of staphylococcic pneumonia, five —62 percent—were of this phage type.

There were cutaneous staphylococcic infections, not related to surgery in 58 hospital patients; 76 percent were 42B/52/81.

Finally, in 87 patients, the prime reason for admission to the hospital was staphylococcic infection, and 16 percent of these patients showed phage type 42B/52/81. This shows that this phage type certainly is present outside of the hospital, but is found predominantly within the institution.

To summarize, the organism isolated from about 70 percent of the infections classified by the committee as hospital-related, were of the 42B/52/81 phage type. The organisms in the remaining 30 percent were of other phage types, or were not typeable.

In the past, a great deal of emphasis has been placed on the nasal carrier in the hospital as an important factor in the spread of these organisms.

During the study, nasal cultures were made on over 600 hospital personnel. Of the personnel cultured, 265 were carriers of a coagulase-positive *Staphylococcus aureus*. This is about 40 percent, about average for hospital personnel.

However, when staphylococci from these positive cultures were phage-typed, it was found that only 11 of the 265, or four percent, were phage type 42B/52/81, the type responsible for 70 percent of the hospital infections.

In addition, these cultures were not consistent; that is, when personnel with positive cultures were re-cultured, frequently the same organisms were not found. Thus, it is reasonable to assume from these figures that the personnel nasal carrier in our institution had little, if anything, to do with the spread of these organisms via the nose and throat. Perhaps too much emphasis has been placed on the nasal carrier, possibly at the expense of other, more likely, sources of infection.

A big problem is locating the source of these organisms and their mode of transmission. Where do they come from? How are they spread? Dr. Schreck, will you say a few words about this?

DR. SCHRECK: This, of course, is the greatest

problem, and really no one has an answer. In the literature on staphylococcal infections, every conceivable route of transfer has been incriminated; once in print, the incrimination is carried from one publication to another pretty much as a dogmatic statement that "this is the way the organism is transmitted." Frequently the first person who took the statement from an article omitted the prefacing statement, "We suppose . . ."

We really don't know how important the air-borne dissemination of this organism is. We don't know how important dust is. We don't know how important the nasal carriers are.

And we will not have the answers to these questions until we can isolate the organism from each of these sources and, even though it is of the same bacteriophage type, determine what its virulence is in each separate source. Then perhaps we can say, "Even though we find this offending organism in dust, it is not virulent."

Surgeons making rounds change from their scrub gowns when they leave the O.R. suite.

Many people have attempted studies to determine differences in virulence, and it is almost impossible. I spent one summer, using experimental animals, trying to compare the virulence of organisms from various areas, and I could tell no difference in virulence.

So, we cannot really state what the true method of spread of the organism is. We can only say that on the basis of our data, on the basis of sheer numbers, we would have to put the person with an active staphylococcal infection at the top of the list of modes of transmission. In turn we would withdraw some attention from the previously-incriminated healthy nasal carriers of the same organism.

DR. CASWELL: A graph showing the incidence of hospital-acquired infections in patients and that of infections in personnel reveals how closely they follow the same curve. There is no doubt that patients can transmit infections to personnel and personnel can give infections to patients. The only way to break the chain is to use meticulous technic, which is nothing new. Primarily such technic consists of washing the hands and wiping them with an alcohol sponge after care of a patient, particularly one who has an infection.

In a study of cutaneous staphylococcal infections in our personnel, it was found that 64 percent of the infections were on either the arm, wrist, or fingers, or the head and neck. These areas are exposed to contamination by the ordinary nursing or medical uniform. There is little doubt that these infections were the result of direct skin contamination.

A summarization of the incidence of infections in our institution showed that the student nurses had by far the greatest number. The figures were: student nurses, 64 infections; registered nurses, 15; interns and residents, 15; aides, orderlies, and others, 5.

Perhaps the reason the student nurses had so many of the infections was that possibly their technic was not quite as good as it should be. And maybe there is a good reason for that. For the last 10 or 15 years, young people coming into nursing and into medicine have not been as afraid of infection as were people in previous years. There is little doubt that even routine aseptic hand care has been sadly neglected by many of our personnel—not only nurses, but physicians as well.

Miss Brown, what did you do about student nurses who developed furuncles and carbuncles in our institution, and how do you control these infections now?

MISS BROWN: The first thing that had to be done was to teach personnel to report the very first sign of any infection. They were told what to look for and when to report.

A number of key people were chosen throughout the hospital to spot these infections in others. Because the majority of them show up on the hands and arms, or face, detection was not difficult.

At the present time, everyone reports an infection as soon as it appears.

As soon as an infection is reported, treatment is started. Most important is taking the nurse off duty and putting her into semi-isolation in the nurses' residence so that she does not spread the infection to either patients or other nurses. She is then followed closely, day by day, until the infection clears; then she can report back to work.

We find that having the same doctor treat these cases, and the same nurse follow them, results in a much better knowledge of exactly what to do in each case.

DR. CASWELL: Most of these infections have been treated very conservatively with simple hot compresses, and incision and drainage when fluctuation is obvious. The nurses have been instructed how to give meticulous care to their hands, using alcohol sponges after they change their own dressings. They use hexachlorophene soap for bathing. Ultraviolet light has been used in some who had infections in localized areas, such as the axilla, and one of our committee members thinks the treatment has a definite beneficial effect in that type of case.

(Continued on next page)

Infected personnel are not given antibiotics, unless they have had multiple severe recurrences or have shown signs of systemic toxicity. We have not used the antibiotics which are effective against these organisms because of our fear of developing an antibiotic-resistant strain.

DR. SCHRECK: To obtain an antibiotic profile for the various strains of staphylococci, we did test-tube determinations of antibiotic susceptibility for 10 different antibiotics.

The organism we are most concerned about, phage type 42B/52/81, was found to be almost completely resistant to penicillin, streptomycin, tetracycline, and polymyxin. Fifty percent of the strains tested were resistant to magnamycin, and almost all the strains were resistant to erythromycin.

The organism type 42B/52/81 as well as the other strains of staphylococci showed good susceptibility to chloramphenicol and novobiocin. In treatment, it was found that bacitracin and neomycin might also be used parenterally under certain circumstances with good results.

DR. CASWELL: On the basis of the marked resistance of these staphylococci to the most commonly used antibiotics, we have formed definite opinions on the so-called routine prophylactic use of antibiotics. Dr. Steel, would you comment on this?

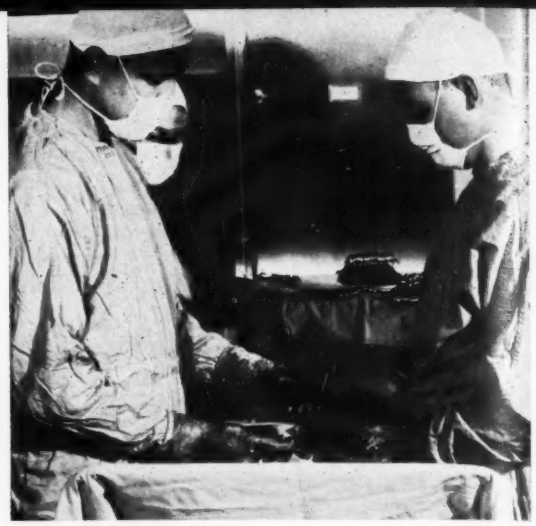
DR. STEEL: We have been categorically against the routine use of antibiotics prophylactically for some time. The practice is prevalent in many services throughout the country, however, and we are very definitely against it for several reasons.

First, I think the prophylactic use of antibiotics may have created the problem we have today. There is a fairly good chance statistically that the use of penicillin in the early days killed off the organism that was only relatively virulent, leaving us saddled, in our own institution, with a strain of staphylococci—42B/52/81—which is highly virulent.

Secondly, there is danger, small perhaps but danger nevertheless, in the administation of penicillin prophylactically. Fevers can be caused by penicillin, which can certainly confuse the clinical picture; people have died after its administration; patients can develop a sensitivity to it, a drug which might be very helpful to them in the future if they develop an infection from an organism still susceptible to penicillin.

DR. CASWELL: What about the prophylactic use of the two drugs—chloramphenicol and novobiocin—which can be used systemically, with safety, in the treatment of these staphylococcal infections, Dr. Carrington?

DR. CARRINGTON: I think their use prophylactically is highly inadvisable, for the very reason that they do provide the only possible means of combating a specific infection. If the drugs are used prophylactically, exactly the same pattern will be established as was established with penicillin, a pattern of resistance. This has happened with at least one antibiotic, erythromycin, in our own hospital, and other hospitals have had similar experiences within a relatively short period of time.



A part of good technic during surgery is making sure that all scalp hair is covered. A mask should cover the nose as well as the mouth.

The safest measure, I think, is to save the drug for use only in those instances in which it is specifically indicated and in which specific organism sensitivity is present.

DR. CASWELL: In clean surgical wounds, it has been our experience that the majority of those which become infected can be handled very well by adequate surgical drainage, without the use of antibiotics.

However, the patient who shows signs of considerable toxicity and spread of the infection requires antibiotics, and the drug should be given promptly and in large amounts.

The same principles apply to patients who develop respiratory infections of staphylococcal origin.

As many have emphasized, there has been a relaxation of hospital and operating-room technics during the latter years of the antibiotic era. The medical and nursing professions have come to regard the problem of infection much less seriously than they did prior to the development of these antibiotics.

Certainly, this whole attitude must be changed. A return to the most strict hospital technics is essential. In addition, every effort should be made to control the potentialities of contact and air-borne dissemination of organisms, both in the hospital wards and in the operating rooms.

Unless these things are done, control of staphylococcal infections in hospital patients is doomed to failure.

We do not feel that we have conquered the problem. The most we can say now is that we seem to have the situation under control at present.

How should the hospital patient who develops an infection be managed? What technic should be used? What, for instance, should be done with a

patient in a semiprivate room who develops a staphylococcal wound infection, Dr. Steel?

DR. STEEL: In the first place, a patient admitted to a semiprivate room for elective surgery should not be placed in a room with a patient who has an infection. In many places, this may be difficult to arrange because of a bed shortage, but it certainly should be arranged at all costs.

The second thing that should be done in the case of a patient with an infection, of course, is to take precautions with his linens. Now, when the bed is changed, instead of putting the used top sheet underneath the patient and giving him a clean top sheet, we change both sheets every two days.

Sheets from a contaminated patient are placed in a marked can outside of the room or in a special bag. They are autoclaved before laundering to prevent laundry personnel from becoming contaminated. Often, the same persons pick up the dirty laundry and deliver the clean laundry, and often in the same cart. If the cart is contaminated, the clean laundry coming back is contaminated also.

Similar precautions are taken with blankets. Most hospitals, and most hotels also, do not sterilize blankets between admissions of patients or guests. We make an attempt to see that a patient gets at least a clean blanket on admission and that the blankets being returned from the laundry are safe, from a bacteriological standpoint.

MISS BROWN: We use plastic covers on all of our mattresses. After the patient leaves the hospital, these are washed, first with soap and water, then with a solution which has some germicidal qualities.

Pillows, and their cases too, are autoclaved, then returned for use. Of course, if they are soiled, they are sent out for complete rehabilitation.

The nurses taking care of contaminated patients must wear gowns. Alcohol sponges are kept at the bedside of every patient with even the slightest case of infection. The nurses and other personnel coming into that room and rendering any care at all to that patient—even touching a glass which the patient has touched—wipe their hands with an alcohol sponge before leaving the patient's bedside.

DR. CASWELL: Control of hospital-related infections does not lie in any single field or in any one spot in the institution. A program of control must apply throughout the hospital, and the most important factor is the attitude of the personnel.

Constant vigilance, care, and alertness about breaks in technic and sources of infection are the real answer to the problem. When these are practiced, then other things can and will be corrected.

MISS GUZARA: What impressed the operating room staff most was the idea that "What you can't see is what should frighten you. It's not the dirt that you see around that you should fear. It's what you can't see that should alarm you."

Small things such as hair escaping from an operating-room cap are possible trouble spots. We looked and looked for a cap which would prevent this, especially for people who have a very low hairline. When we finally found one, we switched to that style, and the nurses are very pleased with it.

DR. CARRINGTON: We found a simple and effective way of insuring that the operative area was properly prepared prior to a surgical procedure. Sterile water, soap, and scrubbing brush are the first step; in all O.R. patients, the operative area is scrubbed before the doctor comes in to do the remainder of the prep. In some patients, the same washing technic is used on the operative area the night before, but in all patients it is used just before the preparation.

Following the soap-and-water scrubbing, we use ether to remove all the surface grease or other material. Then the area is cleansed, and following that, 70 percent alcohol solution is used.

The microbiology department has made a number of studies of various methods, and this one has proved the most satisfactory.

DR. STEEL: Ward rounds should not be made in operating room attire. The bacteria on the ward cling to our clothes and when we go back into the operating room, we take them with us.

DR. CASWELL: It is amazing how many times we have seen a doctor leave the operating room to answer a call about a surgical patient, pick up a dressing—which could well be infected—then return to the operating room in the same clothes. He will remove his gown, and perhaps his gloves, which may or may not have a hole in them, scrub for a minute or two with a magic antiseptic soap, then come back into the operating room.

MISS GUZARA: We try to make it unnecessary for nurses to leave the operating room in their scrub clothes. Many times the physical set-up will cause problems, but an effort must be made to control such situations as far as possible.

No one is allowed to eat outside of the hospital. However, the nurses do not change their clothes if they must go somewhere else in the hospital and return. We find that such situations cannot be completely controlled. They do change clothes completely when they come to work and when they go home, instead of wearing O.R. clothes to and from work, as they did formerly.

We do not let anyone into the O.R. who hasn't exchanged all his outer clothing for a scrub suit.

DR. STEEL: Significant changes have been made in technics of using the dressing carriage. There was a time when anyone could take out a dressing cart when he wanted to and do the dressings without assistance. The only assurance anyone had that the cart was not contaminated was knowing that the person who had used it immediately before practiced good technic.

The question arises whether it is serious if the dressing cart is contaminated. These carts are

(Continued on next page)

After surgery, contaminated linens are placed into a striped bag, which differentiates them from other linens.

STAPH. INFECTIONS continued

used for clean wounds, and it is difficult to infect a clean wound once fibrin has closed it. However, such a technic merely increases the staphylococcal population in the hospital. Our main problem has been to decrease the staphylococcal population, and I think changing the dressing cart technic is one way in which this has been accomplished.

Now we have a trained surgical nurse assigned to the dressing cart for contaminated cases. She checks rather carefully on the doctor doing the dressing and makes certain that his technic is without fault. The instruments used are autoclaved prior to being washed, to protect the personnel who wash them from contamination of their hands.

DR. CASWELL: Autoclaving dressings before disposing of them, and of instruments prior to their cleaning is, we think, an important change in technic. If either are put into a large can or bag someplace, they may be transported all through the hospital; frequently the bag breaks.

One proof of how effectively this system operates is the fact that none of our supply room personnel has had a single cutaneous infection in a year and one-half despite their being responsible for all cleansing of instruments.

MISS GUZARA: Ideally, a separate operating room should be used for contaminated cases. If a separate room is not available, preparations for contaminated cases should be made beforehand. A bag for linen should be provided, marked in some fashion such as with a wide red band, to let the laundry know that it contains contaminated linen. Then the laundry can wash this linen separately and handle it carefully so that the personnel will not become contaminated.

Buckets should be lined with paper bags so that all soiled dressings can be put in one area. Double-thickness paper bags should be used if necessary.

After the surgery is over, someone should be sure that all linen is put into the laundry bag, that all soiled dressings are gathered into the paper bag, and that the instruments, basins, and gloves are all put into the autoclave and sterilized. The blankets from the stretcher are also removed and put in with the contaminated linen. Then the stretcher, the operating table, and the floor are all wiped down with an antiseptic solution.

DR. CARRINGTON: No one with a cutaneous lesion should be allowed into the operating room or in other places particularly susceptible to infection. We feel this problem very seriously in the maternity unit. Any person coming into the nursery with a cutaneous lesion is likely to cause a serious problem in both infants and mothers.

For instance, if such a lesion were permitted within our nurseries, at least 50 percent of the infants' nasal pharyngeal passages would be colonized very shortly. This does not mean that 50 percent would necessarily show clinical infection, but the potentiality is there. And from the infant's nasal passages, the organisms can cause a breast abscess.

The mother doesn't have to have fissures in the nipple to become infected and develop a breast abscess. The normal mechanism of nursing, with the back-and-forth suction and propulsion of the milk by the baby, is perfectly adequate. On two occasions, before we recognized the seriousness of such a situation, we have had a rash of breast abscesses after personnel with infections entered the nursery.

Penicillin and sulfa and other preparations are useless. If a breast abscess develops, there is only one thing to do—incision and drainage.

The methods of care following the incision have changed also. Whereas hot soaks were previously used for a rather long period of time, they are used now only for a day or two until sufficient drainage has been established. The reason is that in a number of patients given hot wet packs for a long period, cutaneous lesions which became very stubborn developed. Sometimes these extended into the axillary region, and it took months of treatment to clear them.

DR. CASWELL: For scrubbing technic prior to surgery, we have returned to a 10-minute scrub with white soap followed by a two to three minute bath in a 70 percent alcohol solution.

We do not think what is used is as important as is the attitude of those scrubbing. Using a two to three minute scrub with a so-called antiseptic soap is not a sound idea because of the difference in the type of people who are using the operating room facilities. Not all are careful, and the dirt absolutely must be removed. It doesn't do any good to put antiseptic solutions on dirt.

DR. STEEL: The problem of dust movement in a hospital is rather grave. Floor-polishing instruments swish it around, and people swish it around with brooms. We have tried to eliminate the dusting in the hospital as much as possible and have substituted wet mopping for dry sweeping.

DR. CASWELL: In summary, infections with these antibiotic-resistant organisms do not constitute a temoprary epidemic, but represent a problem which must be faced for an indefinite period of time in our modern institutions.

Infected hospital personnel play a dominant role in the transmission of these organisms; the role of the healthy nasal carrier in the hospital is equivocal. Control of these hospital-related staphylococcal infections cannot be attained by the discovery of additional antibiotics because resistance to the new agents would probably develop as it has for the ones previously employed. Successful control must be predicated on a return to strict sterile technics combined with intelligent limitations on the use of antibiotic agents.

Discussion

Q. How can you enforce rules accepted and approved by all heads of departments—surgeons, anesthetists, nurses—if the heads of the areas are the first to break them?

DR. CASWELL: The only answer I know of is to have chiefs of the various departments who are afraid of the possible consequences and who have the authority to be stern.

DR. STEEL: If the committee, or the impetus to form a committee, starts at the head of the hospital with the power to hire and fire whomever it will, I believe its rules will be enforced. I think that obtained at Temple, and I am convinced this situation must prevail if the committee is to be effective.

Q. Does air-conditioning possibly spread staphylococcal infections, and if so, how can such spread be prevented?

DR. CASWELL: Much work is being done to reduce the possibility of contamination from air-conditioning. I think a method of sterilizing and thoroughly cleansing air is going to be part of the modern institution of the future. One method now in use employs a hydroscopic agent, lithium chloride, which has resulted in a marked diminution in the bacterial counts of air-conditioning. As yet it has been used only commercially in food-processing plants and pharmaceutical and other industries.

Q. Don't you think surgeons should remove their gloves between cases? Isn't it poor technic for surgeons to go to the phone, for example, with dirty gloves?

DR. CASWELL: Ideally, between cases the surgeon should take his gloves off and go through a full scrub, because bacteriologically speaking his hands are as dirty or dirtier because of the moisture than they were before he started.

Q. What is the maximum length of time following surgery that you could attribute a staphylococcal infection to a break in technic during surgery?

DR. CASWELL: Most postoperative staphylococcal infections that we have seen have occurred in two to four days after surgery. We have seen some severe wound infections occurring eight days after surgery which were unquestionably of hospital origin.

Q. Do you have more than one nurse assigned to dressing carts? If not, how do you handle the problem of three or four doctors who wish to change dressings simultaneously?

MISS BROWN: They wait!

Q. How can you prevent an assistant with an infection and a surgical dressing covering it from scrubbing and assisting if a surgeon demands his help?

DR. CASWELL: The answer to this lies in an effective committee on infections, with good administrative backing. This practice is not only poor surgical technic, but has legal implications.

Q. How often do you culture in the operating room? What methods do you have?

MISS GUZARA: We culture all our equipment, or loads in the autoclave, once a month. We use controls or organisms that the bacteriology department provides.

DR. SCHRECK: We use a small culture of spores. If the autoclave kills spores, it will kill everything.

Q. Do you use water tanks? How often do you culture the water?

MISS GUZARA: Yes, we have water tanks. Cultures are sent over once a month and they are consistently negative.

Q. What is the correct way to dispose of the contents of contaminated suction bottles, and how should the bottles be cleaned?

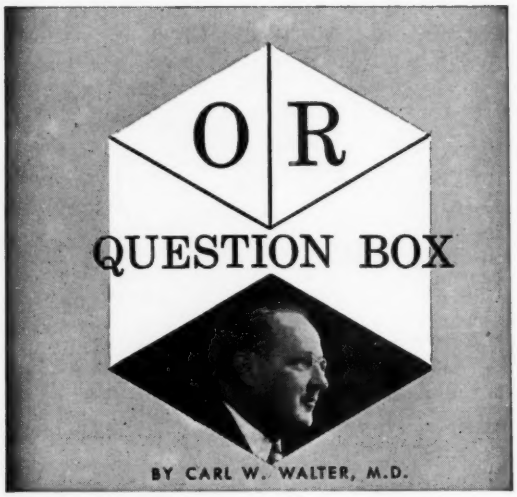
MISS GUZARA: The suction bottles are emptied into a flushing rim hopper sink, and the contents are immediately flushed down. The bottles are not washed. The dirty bottles and tubing are then put into the autoclave and sterilized.

Q. How long are contaminated instruments autoclaved?

MISS GUZARA: We autoclave our contaminated instruments the same length of time that we autoclave our clean ones sterilized between cases—six minutes in the high-pressure sterilizer at 270°F. Studies on clean instruments from a routine case, and then also on instruments from a contaminated case, have shown that six minutes' exposure kills all organisms.

In an old instrument sterilizer which we used previously, instruments were found sterile after 10 minutes.

(Continued on page 94)



Assisted by Dorothy W. Errera, R.N.

Q. Does it make any difference how many basins go into a basin kit?

A. Any number of basins can be included in a kit, provided they are positioned so that each will stand on edge in the sterilizer.

Q. How can we fold a large rubber sheet for sterilization?

A. Impervious material such as rubber cannot be folded because steam will not penetrate to the center. The sheet should be rolled loosely so that there will be a free exchange of air and steam in the center as well as at the peripheral layers.

Q. Do you recommend any regular routine of bacteriologic studies of air-conditioning apparatus?

A. Air-conditioning units need checking at regular intervals. Filters must be cleaned or changed, and cooling coils must be washed with a detergent-germicide. Humidifying pans and recirculated water must be cultured. Air in patient-care areas can be cultured routinely as a check on the efficiency of air-conditioning maintenance.

Q. What do you suggest for routine mattress handling after discharge of the patient?

A. Several technics are feasible. First in order of convenience and safety is use of the ethylene-oxide sterilizer. With this equipment, the mattress is both deodorized and sterilized. If one does not have such equipment, protective barriers which can be disinfected terminally should be provided between the patient and mattress. Plastic mattress covers can be wiped clean with a detergent-germicide. Muslin mattress covers can be laundered when the patient is discharged. Simple vacuuming, using equipment which either collects debris under water or exhausts to the outdoors, provides a measure of safety far greater than that achieved with the vigorous sweeping with a whisk which is so much a part of nursing-arts tradition.

Q. Where would you suggest locating the ethylene-oxide sterilizer in the hospital?

A. An ethylene-oxide sterilizer in the central supply room can be used for processing material used throughout the hospital.

Q. How much deviation in technic is needed to safely handle a communicable disease in the operating room?

A. The surgeon defines the communicable disease and identifies the mode of transmission. Usually such a case can be easily and safely handled with use of any good technic of terminal disinfection of operating room supplies and equipment.

Disease borne in excreta presents no particular problem because instruments and linen are terminally sterilized and laundered before handling. Respiratory diseases are controlled in the anesthesia technic and terminal disinfection of the apparatus.

Q. Do you consider it poor technic to set up an instrument table for a subsequent case in a room in which another operation is taking place? Do you consider it poor technic to mop a room while instruments and linen are open?

A. Air-borne contamination is the overlooked vector in perpetuating sepsis. It is difficult to control under optimal circumstances. During routine activities such as setting up or taking down an operation, air-borne contamination is much greater than at any other times. For this reason, it is unwise to set up an instrument table for a case in the same room while another operation is taking place. Similarly, the room should be wet-mopped before the sterile kits are exposed.

Q. Why are you against using safety razors for surgical shaves?

A. A straight-edge razor leaves a clean, smooth surface, free of hair and desquamating epithelium, whereas the safety razor removes only a fraction of the hair and leaves the patient's skin with multiple cuts and nicks. There is a difference between using a safety razor on the skin of the face, which is shaved daily, and on an area which may never have been shaved before.

Q. I recently read a statement that factory prewrapped items were not suitable for O.R. use. If this is so, can you explain why?

A. Factory pre-wrapped items are satisfactory for use in the operating room if they are well-wrapped during manufacture; clearly marked "sterile"; and properly stored in the hospital. They must be packaged so that contents can be passed to the sterile field without contamination. Perhaps the misunderstanding is related to the fact that these articles cannot be sterilized in the steam sterilizer without being removed from their original wrappers. Beware of articles marked "sterilized." This implies the contents were sterilized at one time but gives no assurance of their current state of sterility.

What every O.R. Nurse should know about A·S·R STERISHARP blades

Q. *What is a SteriSharp?*

A. It is a sterile-packed surgical blade made from a special alloy of extremely hard stainless steel. Like all stainless-steel surgical instruments it will not rust or corrode in hospital use.

Q. *Aren't all sterile-packed blades made from stainless steel?*

A. No, only SteriSharps. All others are made from ordinary carbon steel which rusts, corrodes and dulls quickly when autoclaved or kept in solution.

Q. *Are SteriSharp blades sharper than carbon steel blades?*

A. Yes. SteriSharps' imported high-chrome alloy Swedish steel is hardened, tempered, ground and sharpened under processes developed by A·S·R to give it a sharper, longer lasting cutting edge.

Q. *Can I autoclave the sealed SteriSharp packet?*

A. Yes. Neither autoclaving nor dry-heat sterilizing harms the packet or the blade inside. This means you can include any number of SteriSharp packets on the instrument tray. The sterile nurse can then open blades as needed. And all unopened packets can be returned to stock.

Q. *Can I autoclave SteriSharp blades out of the packet?*

A. Yes. Unlike carbon steel blades which blacken, rust and lose their edge when autoclaved, SteriSharp blades can be autoclaved repeatedly without damage. Thus, SteriSharps which have been opened but not used can be returned to stock. This eliminates blade waste. SteriSharps can be stored indefinitely without harm.

Q. *How does A·S·R make sure that SteriSharps are 100% sterile?*

A. SteriSharps are ultrasonically cleaned before packaging. The packets are sealed securely and are heat-sterilized at a time-and-temperature cycle well above highest hospital requirements. Each lot is sampled *twice*, and blades are tested for sterility by A·S·R's own bacteriologists according to USP XV (revised). Each lot is also checked by an independent laboratory.

Q. *How can I be sure SteriSharps come to me 100% sterile?*

A. Test them in your own laboratory. We will be happy to send you a detailed description of our sterility testing methods.

Q. *Can SteriSharps be re-used?*

A. After their work in the Operating Room, SteriSharps can be autoclaved and distributed to Pathology and other blade-using departments.

Q. *How do SteriSharps compare in cost with other sterile-packed blades?*

A. SteriSharps cost less.

Q. *How do SteriSharps compare in cost with ordinary carbon steel blades?*

A. SteriSharps do away with jars and solutions and eliminate blade waste. In addition, the greater durability of stainless steel means longer blade life. Surgeons report that during procedures where extensive cutting is required, one SteriSharp does the work of as many as six ordinary carbon steel blades. Hospitals using SteriSharps report dollar savings of 25% and more over conventional nonsterile carbon blades.

Q. *Do SteriSharps come in all standard sizes and fit all standard handles?*

A. Yes. In addition, when you contract for SteriSharps, you will receive FREE as many stainless-steel dispensers as you need for your O.R. suite and other blade-using departments.

Q. *How can I find out more about SteriSharps?*

A. Write: A·S·R HOSPITAL DIVISION, DEPT. HT
380 MADISON AVENUE, NEW YORK 17, N. Y.

Literature and samples for your evaluation are available upon request. And if you have further questions—ask us.

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SteriSharps . . . the first and only sterile, stainless-steel surgical blade

● *One of the most popular sessions at the fifth national congress of the Association of Operating Room Nurses in Philadelphia was the panel discussion on communications and methods of improving work relations in the operating room. Two papers from this symposium appeared in the June issue, along with the first part of the question-and-answer period. Because the material deals with technics of solving common problems of O.R. administration and supervision, we are presenting the second and concluding part in this column. Panel members were: J. Thomas Freeston, vice-president, personnel, Ethicon, Inc., Somerville, N.J.; Edmund Kowalczyk, personnel director, Ethicon, Inc., Chicago; and Earl G. Planty, Ph.D., professor of management, University of Illinois, Urbana.*

Q. I have one nurse who is absent at least three or four times a month. Can I do anything about this?

DR. PLANTY: Until you know why she's absent you don't have anything to work on. Is it possible that she just isn't able to come to work or thinks she isn't able to come to work?

Or, are there facilities where she can lie down and rest a little in the middle of the day? If she's suffering from dysmenorrhea, maybe providing such facilities would get her there during this time of the month.

There's no general shotgun treatment for absenteeism, except that the fact she's absent says to you: "I'd rather be somewhere else than on that job!"

You have to find out. Is this her way of saying, "I don't like this job?" If so, why don't you ask her what she doesn't like? Maybe you can transfer her, or change her, or counsel with her. At least hear her complaint! And if it's something you can change, go about changing it.

Q. I have a worker who resents criticism. I always try to reprimand him quietly, and in private, but he sulks for days. What do you suggest?

MR. FREESTON: Since the word "reprimand" was used, it could be that the person who asks that question is approaching this as a "bawling-out." Now some people just love to "bawl out." That's some kind of privilege they feel they have.

The question is: What do we want done? Do we want something done a different way? Or, don't we want it done at all? What are we after?

So our general approach is: What is our objective when we're trying to have a corrective interview with someone?

Once in a while I'd say, let this man sulk. You have to think of the relationship between the sulking and whatever the problem may be on hand.

DR. PLANTY: The implication in the question is that this is an unusual situation. I doubt that it is natural for people to like criticism. I don't like criticism. Am I unnatural and unusual? I have to fortify myself and say: "It's good for you, Dr. Planty, you'd better listen!" And I have to say: "Now don't get red in the face while he's telling you; don't give it away that you're so upset like this!"

If the questioner even went so far as to realize that the man would dislike criticism, maybe she would approach it a little differently.

Q. When the whole attitude in the O.R. is one of not caring, of no pride in the work, of slackness, in spite of the fact that individual members are potentially very good—how does one set about changing so difficult and set a situation? Where does one begin?

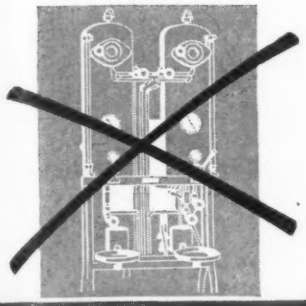
DR. PLANTY: I'd go back to weekly meetings; staff meetings; I'd call the people together, and get the responsibility from ME to THEM as much as I could.

I'd say: "We've been asked upstairs to review our standards," or, "I feel that it might be good to check our standards," or, "I wonder what you think of the standards?" Then I would bring out my expectancies. I'd lay them out to the group, and I'd say: "I believe in cleanliness; this is what we have to do. What do you think of this?" I would settle back and let them take what I had said and tear it apart, and not participate any more than I had to.

I would then take timing and schedules, and promptness, and I would ask: "What standards do you think we ought to set?" I would get them gradually setting standards. People will be part of things that they have built themselves, and will comply with and live with these things.

After all, if you're getting all the fun in making all the decisions—they don't get very interested.

(Continued on page 96)



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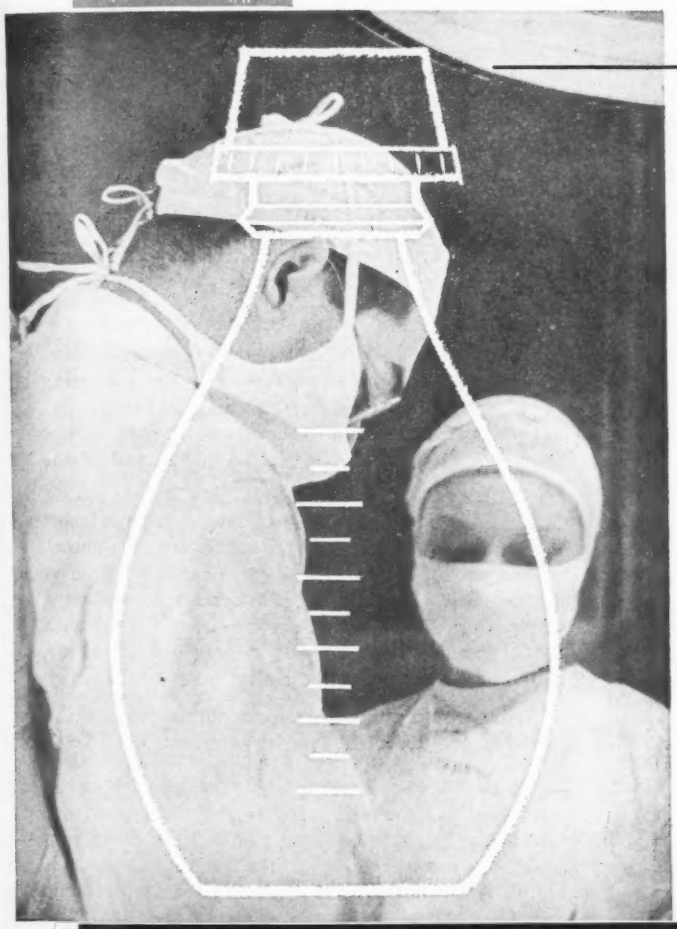

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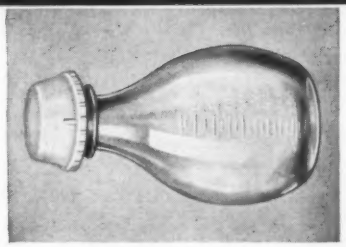

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(Continued from page 89)

Q. How do you autoclave dirty gloves? Bloody in one sack, wet?

MISS BROWN: The doctor takes off his gloves and puts them in the splash basin, and the nurse washes them off at the same time she rinses the instruments, and they are put into the instrument holder. The water from the splash basins is again flushed down a flushing rim hopper sink, and the splash basin is also put into the sterilizer.

We did not get washer-sterilizers because the chamber is too small by one inch to accommodate ordinary splash basins. Large basins would have to be put into a different receptacle, or soaked, or handled in some other way. We found that everything fits into the steam sterilizer; so we autoclave everything.

Q. How often should the masks of operating-room personnel be changed?

DR. CASWELL: Ideally, they should be changed hourly, because of the bacteria count. We just changed from a multiple-layer gauze mask to a simple filter mask. After 20 launderings, the multiple-layer gauze type was just as good as the mask with the little filter, but that means that for 20 launderings it's not, so that's why we changed.

Q. What about visitors to isolation patients on the floors?

MISS GUZARA: They must wear gowns; they must carry out the same technic about changing when they go in to visit the patient, and discarding their gown on leaving.

Q. Would you describe the technic for changing a dressing. Where are your dressing carriages kept?

MISS BROWN: We have one carriage for contaminated cases, with a graduate nurse in charge of it. It is used for all contaminated cases. The nurse knows these by the list that's always available, of cases that cultures show to be contaminated.

This carriage is kept in the central supply room. It is the nurse's responsibility to see that it never becomes contaminated in the process of doing dressings, by keeping it at a certain distance, preferably three feet from the bed in the room in which the dressing is being done. All things necessary are laid out for the dressing and do not go back to the carriage during the process of dressing.

The instruments are placed into a paper bag, and so are the soiled dressings. These are taken to the central supply room and autoclaved, and then the dressings are disposed of and the instruments are washed.

Q. Do the personnel from the central supply room go with the doctor to make the dressing?

MISS BROWN: Yes.

Q. What is the procedure for contaminated cases when they are taken to the recovery room?

MISS BROWN: We do not let our contaminated cases go back to the recovery room. They recover in the operating room in which the case was done. Then the stretcher is brought back immediately. We are fortunate—we have a room which we can set aside for contaminated cases.

Q. When you have breast abscesses in mothers, do you remove the patient from the obstetrical department?

DR. CARRINGTON: We have not had breast abscesses in mothers during their stay in the hospital. The incubation period (of an infection) following nursing is usually two to three weeks after a patient is discharged, and an average of four weeks by the time incision and drainage are carried out, so this question would not be likely to come up.

When a patient is admitted with a breast abscess, she is not of course on the obstetrical floor.

Q. If you have a washer-sterilizer, is it necessary to autoclave the instruments before cleaning them?

MISS BROWN: Of course not.

Q. Do you recommend wet-dusting the operating room in the morning, or dusting it with alcohol, before starting surgery, or would you advise thorough cleansing of the room at the end of the previous day?

MISS GUZARA: Cleaning of the operating room is done by housekeeping department personnel, at the end of the day. If there is time the next morning, it certainly wouldn't hurt to wet-wipe everything down, because you will find that with the air-conditioning on and the circulation of air, your equipment will have a film on it by morning.

Q. What would you advise for a pad in front of the door for the doctors to wipe their feet on?

MISS GUZARA: We now have foot baths at the entrances to the operating room. Anyone who leaves the department and comes back in is supposed to wipe his shoes off in this foot bath, which has in it a thick pad saturated with a disinfectant solution.

Q. Is soaking contaminated instruments in special solutions as effective as autoclaving prior to cleansing?

MISS BROWN: Nothing is as effective as autoclaving.

Q. Where is operating-room and contaminated linen sterilized before it is sent to the laundry?

MISS BROWN: All our operating-room linen is *not* routinely autoclaved before it is sent to the laundry. It is washed separately in the laundry, where they know that it is O.R. linen.

Dr. Schreck and others have done work on the effectiveness of ordinary laundering procedures, and found them quite effective.

Q. Should a mask be used in caring for a staphylococcal infection on the floor?

DR. CASWELL: I think it should. Particularly in patients with staphylococcic pneumonia, I believe it's vital, because instances have now begun to pop up of medical personnel getting a staphylococcal pneumonia from taking care of somebody who had it.

Q. How much time is permitted between a contaminated case and a clean case?

MISS GUZARA: Diligent cleaning is the important thing. If you do it right after the case is over, then you can go ahead and use the operating room. The room is not going to be any cleaner 24 hours later, or even five days later.

Q. What solutions and methods are used on floors?

MISS GUZARA: We wet-mop with a disinfectant solution.*

Q. Who is responsible for examining personnel for infection before assignment to the O.R. and nursery?

MISS BROWN: All the girls have been instructed to report immediately any lesion they may have. Barring this, the supervisor is responsible, and in addition there are spies.

Q. If the doctor must change clothes before he goes to the wards, why should the nurses be permitted to go to lunch in O.R. clothes?

MISS GUZARA: The doctors go out to see patients who are perhaps contaminated, and they are getting in close contact with this organism we are fighting.

As for the nurses, we have been seriously considering wearing gowns over our scrub dresses while we go down to the dining room and then removing them when we come back.

Q. Miss Brown, please comment on the educational programs you developed to combat the spread of infection—for both professional and nonprofessional personnel.

MISS BROWN: For professional personnel, we had, right from the beginning two years ago, meetings with both graduate nurse staff and student nurses, after they had all co-operated with throat cultures. Dr. Schreck met with our graduate staff and discussed at length what we were hoping to do.

We also tried to teach each student nurse what her role was in combatting this problem, and the technic that would be carried out in caring for patients with infections. The students are watching for any infections in themselves.

Now, our student nurses in their first course in bacteriology are getting their first insight into the problem of staphylococcus-resistant organisms. This instruction is carried over into pharmacology in the discussion of antibiotics.

Our biggest problem at first, I believe, was the student nurse or the graduate who got a boil and who immediately rushed to somebody who would give her penicillin. She was raised during the period when penicillin was supposed to cure everything. Our clinic wouldn't give it to her, but there were still plenty of physicians who would.

Measures to prevent infection are covered in the orientation programs for nonprofessional personnel. Alcohol sponges are kept at the bedside of all patients with staphylococcal infections, no matter how slight the infection. Even maids who clean the rooms receive instruction in their orientation program on the technic to follow in these rooms.

When the infection is extreme, isolation technic is used, and nonprofessional personnel do not enter these rooms.

Q. Is it necessary to autoclave masks, either before or after use?

MISS BROWN: We autoclave ours, merely to get them as clean as possible before they are put on. We know that in the process of folding different persons handle them; they might have dropped to the floor, and any number of things might have happened to them. So we autoclave them to get them as clean as possible, but not to keep them sterile.

Q. Do you recommend the use of an alcohol rinse after use of a hexachlorophene scrub, Dr. Schreck?

DR. SCHRECK: No. If you scrub with hexachlorophene, one reason you're using it is for a cumulative effect which after two or three days is better than after the initial use. When you then dip into alcohol, you have destroyed some of that cumulative effect.

Q. Dr. Steel, please give information on preparation for orthopedic surgery.

DR. STEEL: Originally, the orthopedic "prep" was a 24-hour "prep," and the patient came to the operating room in sterile towels. We don't do that any more at Temple, for several reasons.

We try now to make certain that the patient is at least shaved the night before. Incidentally, preferably both the razor and the blade should be discarded between each preparation. I really believe that the razor carries as many bacteria as the blade. The razor is in intimate contact with the patient's skin. If it can't be thrown away, it certainly should be cleaned.

We try to arrange for the patients to wash their feet, and take a shower. It's difficult to carry out this procedure with old ladies who break their hips, but it can be followed in elective surgery on hands and feet.

The preparation in the operating room is a scrub. It takes us about 20-30 minutes to get a hip ready for a nail and plate, because it takes a soap and brush to get a person clean, and that's what we use, followed by ether and alcohol.

*Amphyl (Lehn & Fink Products Corp.).

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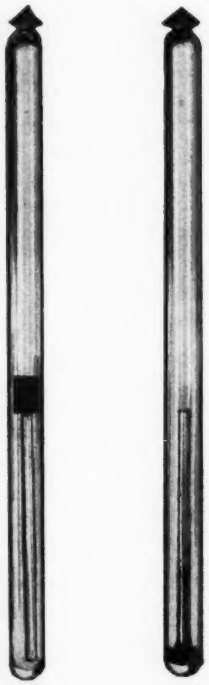

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PROBLEM CLINIC

(Continued from page 92)

Q. Which is more important, charming personality or ability to do the job without the charming personality?

DR. PLANTY: What are you doing, are you running a show for entertainment, or to get the work done?

Some places I want entertaining folks. Usually it's after 5 p.m. Up to that time I have to have performers — I must have performance.

MR. KOWALCZYK: I think there's an interesting division here between charm and efficiency, as if the two are disjunctive continually. Somebody is looking at charm here as sort of a modified form of leprosy—which it is NOT!

Why not be efficient and at the same time smile once in a while? Now everybody doesn't expect you to have a toothpaste-ad smile. You can still be your own grouchy self but be a little more charming about it.

Q. What is wrong with the leader when her workers seem to understand, since for several weeks all goes well—then later they fall into their old habits of not doing their work properly?

MR. FREESTON: Behavior isn't changed by just telling somebody *once* what is to be done. Supervision is a continuous process, involving telling, demonstrating, teaching, reasoning and a host of devices that lead to changed behavior.

It's not abnormal to expect that people need to be told, in different ways, more than once, what's to be done and how to do it. That's normal.

Q. What do you do when a surgeon feels you are being partial to other members of the staff and showing discrimination toward him and his associates and assistants?

MR. KOWALCZYK: "Wherever there's smoke . . ."—you know the rest. In some way, you have left this other surgeon with the impression that you're partial. Maybe you are! Maybe he's right!

So the question that you have to ask very carefully is: How do I best exude an atmosphere of impartiality? How do I go about this? Ask yourself these questions, and again go back to your own mental set in the situation.

Q. The head of our x-ray department will not co-operate with other departments. All other departments must do procedures his way, at his time. Our administrator, to whom the problem was taken, ruled that we must do things the way the x-ray department head wished. What approach could we make to get this man to give some consideration to our side of the problem?

DR. PLANTY: Invite him to your regular or fortnightly meetings. Invite him to come over and sit in and tell your people why he set these standards. Get to know him a little better.

Could it be that your departments don't know each other well enough? That there's not opportunity enough for them to work together; that you don't understand why this man sets the standards he sets; and he doesn't understand why you set yours?

Share some episodes of life outside the job. Try to build a relationship with the person as an individual, because until you get this rapport and respect him, he's not going to accept your product, and you're not going to accept his product either.

Q. What approach should be used by the instructor when she learns that technics set up by the supervisor are contradictory to basic concepts, and the supervisor fails to adhere to principles?

DR. PLANTY: If I were the instructor, I would ask myself: "How come this boss, with all her experience, asked me to do some things that are so crazy?" And I would say, "Am I really *sure* that I'm right?" I would ask a few other people, in other hospitals. I'd phone around a little bit. I'd ask, "How successful has this been in the past?"

Then if I were quite *sure* that my superior was in error, I would see nothing wrong in sitting down and talking with her. I should think she would welcome my suggestions.

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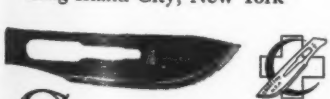

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I'd just go up and say, "I wonder if we can talk about this outline that you've given me. I find a good many of these things very useful, but I did have a question about a couple."

As tactfully as I could, and at the proper time, I would suggest, "Could we improve or change these?"

Q. When a democratic approach fails, should the supervisor assume an autocratic one? What do you advise?

MR. KOWALCZYK: You know your people best. Some people are motivated best by a full sense of participation.

On the other hand, there are some people who feel, if you sit down across the table and discuss things, that: "This hospital must be pretty stupid, because they're asking me for advice." And they feel that the leadership is weak.

Some people need more trenchant directives; some people need sternness; some people have to be told very forcibly what to do.

The democratic approach is not the *only* effective approach. But first of all, by your actions, by your leadership, your people *know* that you're directing this particular enterprise or venture. When they know that, they tend to look to you for direction.

But it's for you to see what buttons have to be pushed on different individuals, because they're not all alike.

DR. PLANTY: Don't confuse democratic with what's called laissez-faire leadership. In a democracy we have presidents and mayors and officers, who give directives and set policies. The opposite extreme of authoritarianism is laissez-faire, in which you abandon your leadership and withdraw. You say: "I'm going to give these people an opportunity now."

Even if you move toward democratic leadership, don't move too fast. People who have not experienced freedom to think for themselves, and for their division, have to be trained in it. They have to be brought along gradually.

(Continued on page 110)

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SELECTED BIBLIOGRAPHY

By Dorothy W. Errera, R.N.

Suggestions will be welcomed for subjects to be covered in future issues.—The EDITORS.

Chandler, Velma L., Pepper, Rollin E., and Gordon, Lee E.: "A Study of Warexin, a New Hypochlorous Acid Germicide." *J. Am. Pharm. Assoc.* 46:124, Feb. 1957.

This study was organized to determine the efficiency of Warexin containing Chlorpactin®, a group of hypochlorous acid compounds, as a hospital germicide. A wide range of organisms were tested—*Clostridium tetani, Clostridium sporogenes,* two unidentified aerobic bacilli, *Proteus vulgaris, Pseudomonas aeruginosa, Shigella dysenteria, Mycobacterium tuberculosis, Candida albicans,* and *Coccidioides immitis.* Technics of culture preparation and test procedures are described in detail.

The bactericidal and sporicidal effects of Warexin were compared with two other hypochlorite solutions containing equivalent amounts of hypochlorous acid. The germicidal effect of the latter two was slightly less than that of Warexin, but when the pH of one of these other hypochlorite solutions was adjusted to that of Warexin, germicidal activity was comparable.

The effect of Warexin in concentrations of 0.25 percent or lower is definitely negated by the presence of organic matter. Solutions of Warexin made from material stored at temperatures higher than 70° F. were not consistently sporicidal.

A solution as dilute as 0.1 percent is highly bactericidal for a variety of micro-organisms tested in the laboratory. A solution as concentrate as 1.25 percent, however, is not sporicidal. Its effectivness is markedly affected by contamination with protein matter and storage above 70° F. It is also highly corrosive to stainless steel used in surgical instruments.

MEMO TO:

THE COMMITTEE ON CROSS INFECTION

Has consistent adherence to your control recommendations been difficult because of the time and trouble it takes? Now there's a practical way--

Turn to page 37

Medrek, Theodore F., and Litsky, Warren: "Surgical Antiseptics." *Surg., Gynec. & Obst.* (Int. Abstr.) 104:209, March, 1957.

More than two hours of hard scrubbing might render the skin sterile. This is an unlikely possibility in any hospital; hence "degermation" is suggested as a more proper term to describe the technics which lower the bacterial counts of skin.

Two types of skin flora are generally recognized—the "resident" organisms—those which are embedded in fat, crevices, and sebaceous glands; and the "transient" organisms—those picked up by contact with things and/or people. The latter are loose on the skin and are easily removed by washing. The resident flora can be effectively reduced by the application of germicides and kept to a minimum by repeated use of such germicides.

When exposed skin meets contaminated surfaces repeatedly, the transient organisms picked up may become highly pathogenic residents. Because the skin has no inherent powers of self-disinfection, antiseptics must be relied upon to reduce bacteria to a safe minimum. A bacterial flora count of 200,000 is considered "surgically secure."

In this review, the authors present a chronological summary of the development of the major skin disinfectants and their relationship to six basic criteria for adequate skin disinfection. These are:

(1) That a disinfectant be effective against both resident and transient flora; (2) that it have a surface tension low enough to allow maximum contact with the surface of the skin; (3) that it be effective in the presence of organic material, including soap; (4) that it be nonirriating; (5) that it have an action which is more than the mere formation of a film on the skin, and (6) that it be inexpensive.

No conclusions are offered, but a critical review is presented of the literature on iodine, the alcohols, the mercurials, Zephiran, pHisoHex, and three more recent antiseptics—Acrizane, Heliogen, and Chlorpactin WCS 90.

Advance AORN Program News To Appear in August Issue

First announcement of some of the speakers and topics for the sixth national congress of the Association of Operating Room Nurses will appear in the August issue of HOSPITAL TOPICS, according to President Pauline Young, R.N., operating room supervisor, Hahnemann Medical College and Hospital, Philadelphia.

The congress will be held at the Shamrock-Hilton Hotel, Houston, Tex., February 9-12, 1959.

CSR Bi-State Group Holds Institute in Kansas City

• A one-day educational institute for central service personnel was held June 6 at St. Luke's Hospital, Kansas City, Mo., under the sponsorship of the Central Service Nurses Association of Missouri and Kansas.

The institute, designed to stress practical knowledge and technics, is part of the educational program of the bi-state central service group which organized on a statewide basis last year.

At a business meeting preceding the institute, the group voted to affiliate with the National Association of Hospital Central Service Personnel. This group thus becomes the first local organization to join the national association since incorporation of the national group in April at the Tri-State Hospital Assembly in Chicago. Membership in the national group is open to all central service staff members.

The Kansas and Missouri group began meeting monthly in the Kansas City area five years ago. Heading the group during its organizational period was Mrs. Betsey Carroll, central service supervisor, University of Kansas Medical Center, Kansas City, Kans., who served as president until last month.

New officers of the group are Harriet Melland, central service supervisor, Grace Hospital, Hutchinson, Kans., president; Gertrude Stumpf, central service supervisor, Kansas City (Mo.) General Hospital No. 1, re-elected vice-president; Mrs. Janet Randell, central service supervisor, University of Missouri, Columbia, secretary; and Marjorie Feleay, central service supervisor, Providence Hospital, Kansas City, Kans., treasurer.

Following are excerpts from some of the talks given at the Kansas City institute.

Prepackaged Dressings Called Time, Labor Savers

Clinical Studies Standardize, Simplify Surgical Dressings

A great contribution has been made to the standardization and simplification of surgical dressings by clinical studies on postoperative wound care. These have resulted in a classification of postoperative wounds from the standpoint of treatment, particularly relating to drainage.

Manufacturers have designed dressings to fit these classifications, thus enabling simplification of dressings.

Following the development of items specifically designed for the various classifications of postoperative wounds, an evaluation was made of the advantages of prepackaged dressings.

It was found, by keeping time and motion study flow process charts in the hospitals, that for most surgical dressings, the small additional cost of prepackaged items was offset by the saving in labor.

In a 350-bed hospital, when 4″x4″ prepackaged dressings were substituted for 8″x4″ bulk dressings, 96,000 fewer units were used in a year's time, resulting in a saving of $1,587. Large savings in money were recorded in other hospitals, indicating greater control of use of products and less waste with use of prepackaged items.

In addition to a saving in labor and money, another advantage of prepackaged dressings is improved aseptic technic. In a study made in a West Coast hospital, reduction of postoperative wound infection when prepackaged dressings were introduced was found to be more than 80 percent. —*H. C. McNamer, Jr.*, manager, midwest hospital division, Johnson and Johnson.

(Continued on next page)

New and outgoing officers of the Central Service Nurses Association of Missouri and Kansas are: (seated, left to right) Gertrude Stumpf, central service supervisor, Kansas City (Mo.) General Hospital No. 1, re-elected vice-president; Mrs. Betsey Carroll, central service supervisor, University of Kansas Medical Center, Kansas City, Kans., past president; Patricia Tolle, central service supervisor, Research Hospital, Kansas City, Mo., past secretary; (standing, left to right) Harriet Melland, central service supervisor, Grace Hospital, Hutchinson, Kans., president; Marjorie Feleay, central service supervisor, Providence Hospital, Kansas City, Kans., treasurer; Lois Collins, central service supervisor, Menorah Medical Center, Kansas City, Mo.; and Mrs. Janet Randell, central service supervisor, University of Missouri, Columbia, secretary.

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CSR Supervisor Often Acts As Purchasing Agent

Dual Role Enables Her to Control Inventory, Use, Care of Supplies

Just as rapid changes are taking place in the entire field of medicine, changes are taking place in the role of the central supply supervisor regarding purchasing.

In the not too distant future, these supervisors will be buying bones, veins, arteries, and kidneys. They will carry out a dual job, however, and also dispense these items.

An advantage of this situation is that the supervisor may solve storage problems in the hospital by keeping the inventory small. She is able to keep equipment in good working order and knows when replacement and repairs are necessary. She controls usage and keeps equipment available.

Intelligent purchasing means knowing when to buy at the best price and buying only supplies that are needed. Constant comparing of prices, and standardizing of supplies and equipment help keep costs down. — *Mrs. Harriett Melland, R.N.*, central supply supervisor, Grace Hospital, Hutchinson, Kans.

Proper Equipment Is Vital For Effective O_2 Therapy

Complete Records of Use Must Be Kept for Realistic Budgeting

Oxygen, important in patient care in many situations, has often been used haphazardly. For proper oxygen therapy, equipment must be in good working order. The care of oxygen equipment requires constant attention.

The storage of oxygen equipment is a problem which can be solved by setting up a systematic procedure.

Functioning equipment should be stored in one place; equipment needing repairs in another.

Hospital engineers may make racks and trays for the storage of equipment, thus providing the proper receptacles for storing each individual piece.

Valves may be mounted on a board. Rubber masks, which deteriorate easily, may be hung on straps.

Oxygen tents must be washed and sterilized before being stored. A rubber garden hose or a dishwashing brush which holds a detergent in the handle may be used for washing. Vinegar in the rinse water maintains the clarity of the plastic. After washing, the tents should be sterilized by means of cold sterilization.

The mechanical chamber and coils of oxygen tents should be checked monthly to see that they are in operable condition and ready for immediate use.

Old equipment should be replaced when necessary; this practice results in greater economy, as records have shown.

Oxygen therapy may contribute to a hospital's deficit if accurate records are not kept and each patient is not charged for the material and service he has received. —*Gareth Gish*, technical sales department, Puritan Gas company, Kansas City, Mo., and instructor in department of surgery, University of Kansas Medical Center.

Good Training Program Is Carefully Planned in Advance

Non-Professional Workers Should Know Their Function on Team

A training program in the central service department begins with a job roster—a card or a chart—on which are shown the department, station, job title, date, name of employee, date assigned, and age.

Job specifications list every duty the employee on that job will be expected to perform.

A job rating form provides a means of evaluating the employee's training needs. On the basis of this, the extent of the training program is determined and plans are made.

A job breakdown is then made, consisting of descriptions of procedures for the tasks to be performed.

These procedures must then be taught by someone clearly designated to carry out the training program—one who is free to do so without the interruption of administrative duties.

The non-professional worker is

Above left: Patrician Tolle (right) assists Betsey Carroll in adjusting the orchid corsage Mrs. Carroll was given by the central service nurses in recognition of her work as chairman of the group for four years.

Below, left: Among the members who attended the institute luncheon were (l.) Evans Webster, central service supervisor, and Mildred Durr, director of nurses, both of Coffeyville (Kans.) Memorial Hospital.

Above, right: Participants in the institute program included Richard E. Burgess (l.), director of technical services, and Carroll Devine, assistant to sales manager, both of Pharmaseal Laboratories, who gave talks on "Better Patient Care with Plastics;" and Mary Helen Anderson, who spoke on "Developing Standardization Within Central Service." Miss Anderson is chairman of the National Association of Hospital Central Service Personnel.

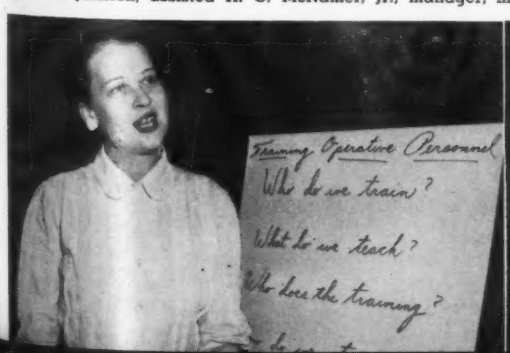
Below, right: Oxygen therapy service and equipment was discussed by Gareth Gish, member of the technical sales department of the Puritan Gas Company, Kansas City, Mo., and an instructor in the department of surgery at the University of Kansas Medical Center. He is shown here with Mrs. Bernice O'Reilly, head nurse in central service at St. Luke's Hospital, Kansas City, Mo., and program chairman for the institute.

a particular responsibility of the person in charge of training. This worker needs to be taught hospital ethics and behavior, and must be taught how hospitals differ from other businesses.

She needs to know the importance of her job, and to understand the vital role that cleaning, packaging, and sterilization of hospital supplies plays. She should be made to realize that carelessness in the timing of an autoclave can mean a serious and possibly even fatal infection for one or several patients. —*Helen Reynolds, R.N.*, director of in-service program, Research Hospital, Kansas City, Mo.

Below, left: Helen Reynolds, director of in-service program, Research Hospital, Kansas City, Mo., spoke on "Educational Programing for Nurses and Auxiliary in Central Service."

Below, right: Don Meyer (l.), Kansas City representative of Johnson & Johnson, assisted H. C. McNamer, Jr., manager, midwestern hospital division, in presenting his talk on "Pre-Packaging —the New Trend." Mrs. Erma Thomason, central service supervisor, VA Hospital, Excelsior Springs, Mo., and Mrs. Mary Olive Hageman, central service supervisor, VA Center Hospital, Wadsworth, Kans., discuss a problem with Mr. McNamer following his talk.



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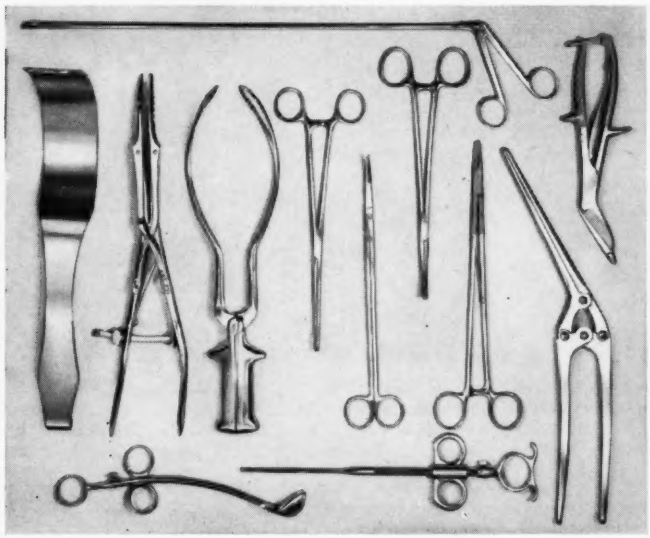

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The Book Corner

Cost Finding for Hospitals. Chicago: American Hospital Association. 1957. 136 pp. $3.50.

The committee on accounting and statistics of the American Hospital Association recognized early the need for combining uniformity of principle with flexibility of application in hospital accounting. Section I of a series of handbooks on accounting and statistics, *Uniform Hospital Statistics and Classification of Accounts*, was published by the AHA in 1950. Section II, *Bookkeeping Procedures and Business Practices for Small Hospitals*, was published in 1956. *Cost Finding for Hospitals* is the third section in this series.

The book will be a valuable contribution to the field of accountancy. It has merit not only as a specialized source of information, but also as a supplementary text for instructional purposes. Its clear, A-B-C method of presentation is ideal for the hospital administrator who wishes a logical approach to the rudiments of cost accounting.

There are five chapters and three appendices. The chapter titles indicate the smoothly written format of the book. They are: the nature and use of cost data; general cost finding procedures in hospitals; cost finding procedures illustrated; special cost studies; introduction to budgetary procedures in hospitals.

The appendices list schedules of possible bases for allocating the direct costs of new cost centers, for distributing general service costs, and special service costs.

Chapter I, in 16 well-written pages, covers the theory of costs succinctly and accurately. The committee points out: "By exercising their prerogatives, department heads and administrators may have strong influence on costs. It is necessary for them to utilize all management technics, including sensible use of cost data..." This is a refreshing approach. Costs and cost finding are put into proper perspective.

Chapter II is procedural. The six basic requirements of cost finding are outlined. The all-important selection of cost centers is stressed. The reader is never allowed to lose sight of the fact that adequate functional classification for direct costs will simplify the approach to cost finding.

In chapter III, the procedures of chapter II are expanded to 48 pages of step-by-step illustration. Three full-page worksheets, with 38 supporting schedules, cross-indexed to the tiniest detail, are provided.

Chapter IV describes special cost studies, and Chapter V gives a sound introduction to budgetary procedures.

The publication of this book makes available accounting procedures for hospitals which, properly applied, will result in more efficient operation and in establishment of patient charges that will more accurately reflect costs of operation. Hospitals have been run too long on the principle of "robbing Peter to pay Paul."—*John H. Gorby*, director of research, Project W-34, U.S. Public Health Service, San Diego, Calif.

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These students in the University of Chicago graduate program in hospital administration have been appointed to administrative residencies for the coming year. Front row (l. to r.): Gerald B. Cole; Jerry L. Buckingham; Lauro Vivaldo-Fernandez, M.D.; Dean E. Leiser; James R. Shawver; Jack C. Robinette. Second row: Thomas E. Coull; Lee Pridgen, Jr.; David L. Allen; William L. Boyd; Thomas J. Broderick; Alfred J. Sparkes, Jr. Third row: So Zimmermann, coordinator; Vernon Forsman, associate director; Ray E. Brown, director; Irvin G. Wilmot, James A. Connelly, and David M. Hatfield, assistant directors.

PERSONALLY SPEAKING

(Continued from page 49)

Col. Raymond T. Jenkins, USAF (MC)—has been assigned as deputy director of plans and hospitalization, Office of Surgeon General, USAF. He was formerly Surgeon of the Twelfth Air Force.

Clifford Johnson—succeeds the late **Clifford Bass** as administrator, Jefferson Davis County Hospital, Prentiss, Miss. He was formerly business manager, Forrest General Hospital, Hattiesburg, Miss.

Emmett R. Johnson—has been appointed assistant administrator, Baptist Memorial Hospital, Jacksonville, Fla. Previously he was administrator, Western Baptist Hospital, Paducah, Ky.

Succeeding Mr. Johnson as administrator of Western Baptist is **Ben R. Brewer,** formerly assistant administrator, Georgia Baptist Hospital, Atlanta.

Eleanor C. Lambertsen—now assistant professor of nursing, Teachers College, Columbia University, New York, N.Y., will assume full-time duties on Oct. 1 as assistant secretary, American Hospital Association's Council on Professional Practice, and secretary of the council's committee on nursing. **Elton T. TeKolste** and **Jack W. Owen** have been appointed assistant secretaries of the AHA's Council on Administrative Practice.

Helen B. Leavitt, R.N. — formerly assistant director of nursing service, Seattle (Wash.) General Hospital, has been named director, succeeding **Mrs. Lea M. Kennedy,** who retired.

Mrs. Tama Lee, R.N.—has been appointed director of nursing service, Tyler Holmes Memorial Hospital, Winona, Miss.

Edgar Little—succeeds **Pat Clement** as administrator, Hancock County Memorial Hospital, Bay St. Louis, Miss.

James V. Lowry, M.D.—has been appointed chief of the Bureau of Medical Services, U.S. PHS, and assistant surgeon general, succeeding the late **John W. Cronin, M.D.** Dr. Lowry was formerly deputy chief.

Robert O. Loosley—has been named director of program development, Yale-New Haven (Conn.) Medical Center, succeeding **Hiram Sibley** who resigned to join the staff of the American Hospital Association. Mr. Loosley was formerly managing director, United Community Services, Detroit.

Jauniece Luther—has been appointed head dietitian, Northeast Mississippi Hospital, Booneville. At the same hospital, **Leroy Henderson** has been named purchasing agent.

The Reverend O. G. Matthews—has been appointed chaplain, South Florida Baptist Hospital, Plant City, Fla. He is a retired Army chaplain and has also served as chaplain in VA hospitals.

A. James McAdams, Jr., M.D.—is pathologist, Children's Hospital of the East Bay, Oakland, Calif.

Bernard McCarthy—has resigned from the staff of Pennsylvania Hospital, Philadelphia, to become assistant executive secretary, Ontario Hospital Association, Toronto, Ont., Canada.

Nancy McElroy—has been appointed dietitian, North Mississippi Community Hospital, Tupelo. She had held a similar position at Georgia Baptist Hospital, Atlanta.

Floyd Miller, Jr.—is now administrator, Belle Glade (Fla.) Memorial Hospital. He succeeds **Donald D. Parke,** who resigned.

George A. Miller—has been named assistant executive director, Unity Hospital, Brooklyn, N.Y. He was formerly assistant administrator, Monmouth Memorial Hospital, Long Branch, N.J.

Marvin Minear—has become business manager, Indian River Memorial Hospital, Vero Beach, Fla. Previously he held the same post at Blount Memorial Hospital, Maryville, Tenn.

L. Christian Moore—has been named administrator, Winslow (Ariz.) Memorial Hospital.

Lonnie Moore—has become administrator, Citrus Memorial Hospital, Inverness, Fla.

James P. Neal—will be administrator, Community Hospital, Evanston, Ill. He has been administrator, Wheatley-Provident

Hospital, Kansas City, Mo.

William G. Nelson—has been appointed administrator, Putnam Memorial Hospital, Palatka, Fla. Previously he was administrator, Bradley County Memorial Hospital, Cleveland, Tenn.

Juul C. Nielsen, M.D.—has been appointed superintendent, Hastings State Hospital, Ingleside, Nebr., succeeding **Jack A. Wolford, M.D.**, who resigned.

Dr. Nielsen had been superintendent, Central State Hospital, Petersburg, Va. He headed the Hastings hospital previously from 1933-42 and again from 1945-51.

Carroll Ogren—is now assistant administrator, Washoe Medical Center, Reno, Nev.

Stuart D. Ogren—is new administrative assistant, Orange Memorial Hospital, Orlando, Fla.

Donald D. Parke—has been appointed administrator, Citrus Memorial Hospital, Inverness, Fla. He was formerly administrator, Belle Glade (Fla.) Memorial Hospital.

Gordon Parsons — has been appointed director of personnel, Abington (Pa.) Memorial Hospital.

Mrs. W. T. Pattie, R.N.—has been appointed superintendent of nurses, Beacham Memorial Hospital, Magnolia, Miss. She was formerly affiliated with Charity Hospital and Touro Infirmary, both in New Orleans.

Conrad Peterson—has been appointed assistant to the administrator, Good Samaritan Hospital, Puyallup, Wash.

Mabel C. Prevost — has been named administrative assistant, Jefferson Medical College Hospital, Philadelphia.

Francisco G. Quesada—has become administrator, Pacific View Hospital, Hermosa Beach, Calif., succeeding **H. Melvin Tupper.** Mr. Quesada formerly headed Huntington Park (Calif.) Community Hospital.

Mark G. Risser, M.D.—is now superintendent, Wernersville (Pa.) State Hospital, replacing **Paul A. Petree, M.D.**, who resigned. Dr. Risser was formerly superintendent, Hollidaysburg (Pa.) State Hospital.

Joffre M. Rothenberg—has become administrator, Garden Grove (Calif.) Hospital, replacing **Murray Shell.** Previously Mr. Rothenberg was comptroller, Johns Hopkins Hospital, Baltimore.

James Skaham—succeeds **George Masters** as head, McCune-Brooks Hospital, Carthage, Mo.

William J. Skerry—has been appointed administrator, Somerville (Mass.) Hospital. He was formerly assistant director, Malden (Mass.) Hospital.

Ray Snyder—has become manager, Palo Verde Hospital, Blythe, Calif., replacing **Kenneth S. Piggott.** For the past four years Mr. Snyder has owned and operated Villa View General Hospital, San Diego, Calif.

Clarise Thompson, R.N.—has been appointed director of patient care, Brewster Hospital, Jacksonville, Fla.

At the same hospital, **Pearl Haff** has been named assistant to the administrator.

Mrs. Dottie Thomas—has been named administrator, Adams Hospital, Panama City, Fla., succeeding **Jack L. Moore.**

William H. Thrasher—has been chosen administrator for a new 200-bed general hospital to be constructed in DeKalb County, Ga. He has been administrator, Athens (Ga.) General Hospital.

Mrs, Marian A. Vuylstek, R.N.—has been appointed administrator of the new Community Memorial Hospital, Missouri Valley, Iowa. She had been administrator, Tilden (Nebr.) Community Hospital.

Daniel B. Watson — succeeds **Harry A. Davis** as administrator, Montfort Jones Memorial Hospital, Kosciusko, Miss. He was former head of the Jackson (Ala.) Hospital. Mr. Davis will head the Simpson General Hospital, Mendenhall, Miss.

Burton Watts—is administrator, Covington County Hospital, Collins, Miss. He succeeds **Mrs. M. G. McLemore.**

A. J. Woodring—has been appointed assistant director, Hospital and Clinics, University of Florida, Gainesville. Previously he was administrator, Fairfield County Memorial Hospital, Winnsboro, S.C.

Ronald W. B. Wyatt—has been named administrative assistant, Samuel Merritt Hospital, Oakland, Calif. He has been serving an administrative residency at San Diego County (Calif.) General Hospital, and previously was administrative intern, Peralta Hospital, Oakland.

John E. Zimmerman—credit manager, is now assistant administrator, Belle Glade (Fla.) Memorial Hospital.

VA Appointments

Harold J. Madsen, M.D.—has been appointed manager, VA Hospital, Fort Lyon, Colo. He was formerly director of professional services, VA Hospital, Downey, Ill.

George J. Weinstein, M.D.—chief of mental hygiene clinic, VA New York City regional office, has been transferred to Washington, D.C. as chief of VA outpatient psychiatry.

(Continued on next page)

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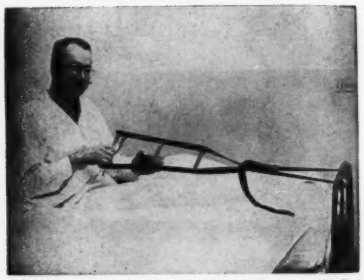

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VA Nursing Appointments

Margaret Buchanan—is assistant chief, nursing education, VA Hospital, Durham, N.C. She was formerly at Mountain Home, Tenn.

Mary Calnan—has been transferred from VA Hospital, Downey, Ill., to Manchester (N.H.) VA Hospital as assistant chief, nursing education.

Julia Hockstatter—has been named assistant chief, nursing education, VA Hospital, Sepulveda, Calif. She held a similar position at Downey, Ill.

Alvin Kern—is now chief, nursing service, VA Hospital, Salisbury, N. C., after holding a similar position at Murfreesboro, Tenn.

Eugene Martin—has been appointed assistant chief, nursing education, VA Hospital, Roseburg, Ore., where he was formerly an instructor.

E. Marion Shelhimer—is chief, nursing service, Murfreesboro (Tenn.) VA Hospital, where she was formerly assistant chief, nursing service.

New Officers

Walter J. Rome, executive director, Children's Hospital of Pittsburgh, has been elected president of the Hospital Association of Pennsylvania, succeeding **James C. Kirk,** administrator, Pottsville (Pa.) Hospital. **Ray K. Bolinger,** administrator, Robert Packer Hospital, Sayre, Pa., was named first vice-president. Officers re-elected were second vice-president, **Mabel A. Barron,** administrator, Ellwood City (Pa.) Hospital, and treasurer, **Joseph W. Bishop,** administrator, Hahnemann Hospital, Scranton, Pa.

* * *

A. L. VanHorn, M.D., medical director, Kate Macy Ladd Convalescent Home, Far Hills, N.J., was inducted as president, New Jersey Hospital Association. New officers elected were: president-elect, **David V. Carter,** administrator, Fitkin Memorial Hospital, Neptune, N.J.; vice-president, the **Rt. Rev. Msgr. F. M. J. Thornton,** St. Mark's Rectory, Sea Girt, N.J., Bishop's Representative for Hospitals. **Nelson O. Lindley,** administrator, Somerset Hospital, Somerville, N.J., was re-elected treasurer. **J. Harold Johnston** continues as executive director.

* * *

Mrs. Margaret Jagger, R.N., is president, Mississippi State Nurses Association. She succeeds **Elizabeth McLaughlin,** R.N., former chief nurse, VA Hospital, Jackson, Miss., who has accepted a similar position in Phoenix, Ariz.

* * *

The Northeast Arkansas Hospital Council recently elected as president, **Robert A. Berryman,** administrator, Randolph County Memorial Hospital, Pocahontas. **John S. Cherry,** superintendent, Chickasawba Hospital, Blytheville, was named secretary.

* * *

Albert E. Carlin, business manager, Matthews General Hospital, Burlington, Wash., was recently elected president of the Skagit Valley (Wash.) Hospital Council, succeeding **Mrs. Alice Duncan, R.N.,** administrator, Anacortes (Wash.) Hospital.

Henry S. Rogers, administrator, Memorial Hospital, Sedro Woolley, Wash., was chosen secretary-treasurer.

Deaths

John A. Judge—administrator, Johnstown (Pa.) Hospital, died April 15. He had served at the hospital for six years.

Curtis Gage Lewis—43, administrator, Springdale (Ark.) Memorial Hospital, until his resignation recently due to ill health, died April 30.

Ralph E. Young—59, business manager, Topeka (Kans.) State Hospital, died April 29. A member of the hospital staff since 1949, Mr. Young was instrumental in reorganizing the business operations of the institution. He developed a payroll accounting system which was later adopted by the Kansas State Department of Social Welfare for all its institutions.

TRADE TOPICS . . .

Award winners in exhibit competition sponsored by Hospital Industries Association at annual meeting of Ohio Hospital Association, held in Cincinnati recently, are, left to right: Robert Ling, Surgical Products Division, American Cyanamid Co., honorable mention, single booth; William Miller, Cutter Laboratories, first prize, single booth; Wayne B. Foster, administrator, Holzer Hospital, Gallipolis, O., and immediate past president, Ohio association, who presented awards; E. C. Johnson, Hill-Rom Co., Inc., first prize, multiple booth; R. H. Sonnenberg, Simmons Co., honorable mention, multiple booth.

Lehn & Fink Expand Technical Services

Two technical representatives have been added to Lehn & Fink Professional Products Division to increase its disinfectant services in hospitals and institutions.

Robert E. Dickens will have headquarters in Atlanta, Ga., and Charles E. Kremis will be in Chicago. Warren Reid has been transferred from Atlanta to Washington, D.C., to augment technical services in the middle Atlantic area.

Du Pont Serves Nutrition Field With Newsletter, Grants

Publisher of a new monthly review and summary of current developments in the field of nutrition is E. I. DuPont de Nemours & Co.

"Nutrition and Health" is designed for nutritionists, dietitians, home economists, and members of the medical and allied professions who wish a brief, informative newsletter on this subject.

Nutrition research grants totaling nearly $400,000 over the past five years have been awarded by DuPont to universities, colleges, medical schools, and laboratories to supplement the company's own studies of amino acids. These grants are in addition to their regular program of aid to education.

Narda Ultrasonics Acquires Alcar Instruments

Narda Ultrasonics Corp., Mineola, L. I., has acquired Alcar Instruments Inc., Little Ferry, N.J. Alcar, specializing in ultrasonics research and development, will be operated as an independent subsidiary, with production and research activities continuing under the same management at Little Ferry. Sales offices will be moved to Mineola.

New Vice-president Named By National Laboratories

M. E. Peck has been elected executive vice-president, National Laboratories, Inc. Mr. Peck, formerly president, Spirella Co., Inc., and Spirella Co. of Canada, Ltd., assumed his new position on June 1.

V. Mueller Names New Officers

George M. Wallerich, president, V. Mueller & Co., has announced the election of John C. Denison as vice-president, and Charles Hough as secretary of the company.

Name Vice-president, Seamless Rubber Co.

Mr. Simpson

Arthur P. Simpson, Jr., has been appointed vice-president in charge of marketing, Seamless Rubber Co. Mr. Simpson will be responsible for all phases of sales, advertising, and merchandising. He had previously spent 17 years with Montgomery Ward where he held various assignments in sales, buying, and merchandising.

Mr. Schlosser

New manager of the Hospital Division, Seamless Rubber Co., is Alan E. Schlosser. He was formerly district sales manager and director of sales training, Bauer & Black Co.

Doctors-in-Training Receive Medical Exhibit Awards

The first Student American Medical Association-Lakeside Laboratories awards were presented for outstanding medical exhibits at the recent SAMA convention.

Top awards of $500 each and the opportunity to exhibit at the American Medical Association meeting in San Francisco went to Quinton Callies, junior at the University of Wisconsin School of Medicine, and E. R. Duffie, M.D., intern, Raymond Blank Memorial Hospital, Des Moines. Ia.

McCallister Named President Of National Drug Co.

Charles McCallister, president, Jensen Salsbery Laboratories, has

(Continued on next page)

been named president and general manager, The National Drug Co. Both companies are subsidiaries of Vick Chemical Co.

Dr. Vladimir Dvorkovitz, former vice-president and assistant general manager, will head Jensen-Salsbery.

Lederle Awards Grant To Johns Hopkins

A $5,000 grant has been made to the division of clinical pharmacology, Johns Hopkins University Hospital, by Lederle Laboratories, American Cyanamid Co. The grant is for a study on "Controlled Quantitative Comparison of Pharmacologic Agents in Man."

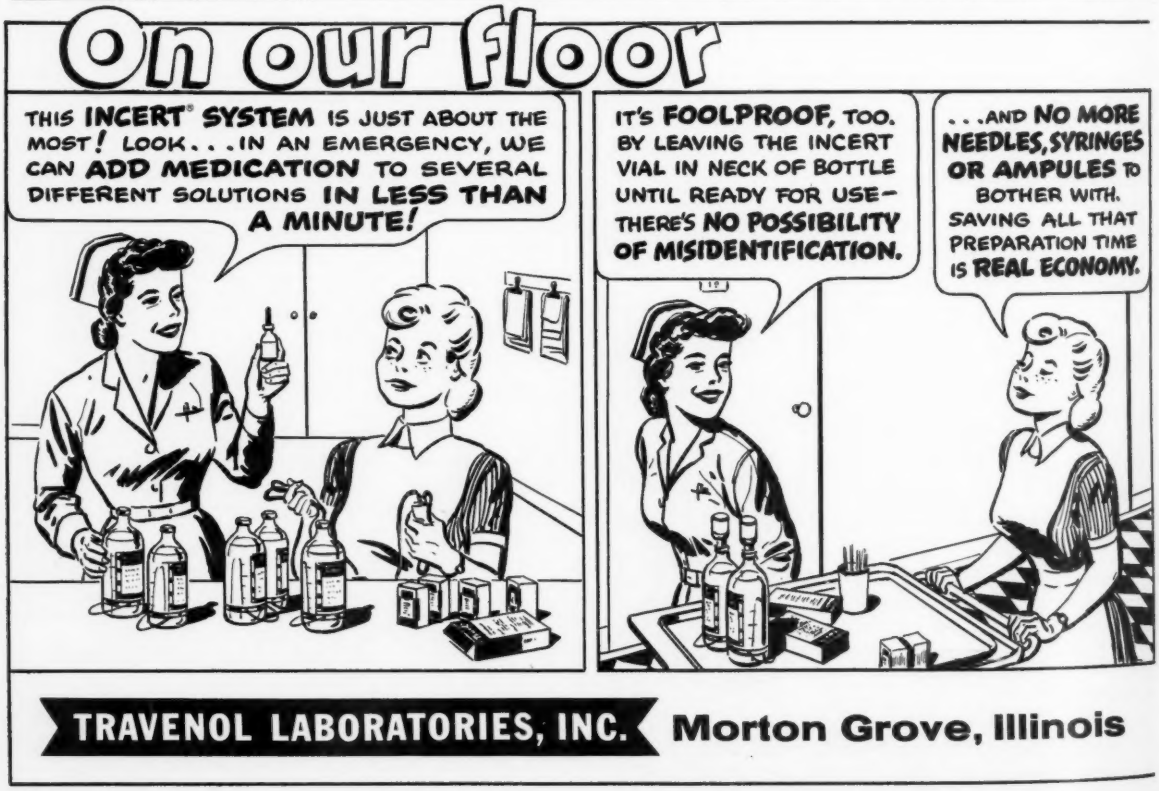
The work will evaluate selected drugs as sedatives, hypnotics, and tranquilizers, and will also involve the testing of agents for cancer chemotherapy.

Nine recipients of funds from the $10,000 Lederle Laboratories research grant to hospital pharmacy were honored at a dinner meeting of the American Society of Hospital Pharmacists, held during its recent convention in Los Angeles.

The Chicago plant of Johnson & Johnson recently celebrated its 25th anniversary with an open house at which company officials were hosts. Shown above at a reception for members of the press are (l. to r.): W. L. Robertson, plaster mill plant manager, John Allan, gauze and baby products mill plant manager, both of Chicago, and George F. Smith, New Brunswick, N. J., president of Johnson & Johnson.

The company also announced that its North Brunswick, N. J., plant has been named one of the ten best new buildings constructed last year among nearly 1,000 nationwide entries. The award was made by *Factory Management and Maintenance*, a McGraw-Hill publication. Selection was based on the company's adaptability to changes in production methods and processes; provisions for growth and expansion; plant electrical services; services other than electrical; employee facilities and services; maintenance; and appearance of buildings and grounds.

Leo F. Godley, A.S.H.P. president, announced the following winners: Donald M. Friedman, James Elieff, and Calvin C. Gilliam, all of the VA Center, Los Angeles; Gerald M. Kramer, North Glendale (Calif.) Hospital; William M. Heller, chief pharmacist, University of Arkansas Medical Center, Little Rock; Paul F. Parker, director, di-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vision of hospital pharmacy, American Pharmaceutical Association, Washington, D. C.; Herbert L. Flack, chief pharmacist, Jefferson Medical College, Philadelphia; Don E. Francke, University Hospital, Ann Arbor, Mich.; and Alex Berman, assistant professor, College of Pharmacy, University of Michigan, Ann Arbor.

Pharmaceutical Publication Names New Editor

Harry E. Carnes, M.D., Parke, Davis & Co., a member of the firm's clinical investigation staff for the past 10 years, has been appointed director of medical correspondence and editor of *Therapeutic Notes*.

Dr. Carnes will handle medical review and approval within the company's sales division and will also assist as consultant in the medical education and training of the sales staff.

Two New Directors Named By American Hospital Supply

J. J. Griffitts, M.D., president, Dade Reagents, Inc., and J. Roscoe Miller, M.D., president, Northwestern University, Evanston, Ill., have been elected to the board of directors, American Hospital Supply Corp.

They are the first physicians to serve on the company's board, and their election increases the director group to 11. Nine directors are officers of the corporation or its subsidiaries.

* * *

James K. Nelson—has been appointed administrative assistant to C. G. Schmidt, vice-president, American Hospital Supply Corp. Mr. Schmidt is in charge of the Scientific Products Division. Mr. Nelson succeeds John Carter who will join the administrative staff of Scientific Products' San Francisco division.

Mead Johnson Names Three To Board of Directors

One of the nation's foremost surgeons and two top men in the field of management have been elected

(Continued on next page)

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TRADE TOPICS continued

to the board of directors, Mead Johnson & Co.

The new directors are Isidor S. Ravdin, M.D., surgeon-in-chief, University of Pennsylvania Hospital, Philadelphia; Arthur M. Weimer, Ph.D., dean, Indiana University School of Business, Bloomington; and Robert E. Sessions, a Mead Johnson executive vice-president.

OR PROBLEM CLINIC

(Continued from page 97)

Q. As a supervisor, how would you handle the following situation? Orderlies and nurses' aides belong to a union. When you ask them to do a certain task, they refuse, saying: "That is not my job."

MR. KOWALCZYK: A union is an organized group of people, which reflects the atmosphere of the people around it. In many cases the way to handle this problem is to insist on written job specifications —a delineation of the proper duties. This is interesting, because usually it's the union that insists on them. So if the union doesn't become aggressive in this, as a part of management, I *would.*

First of all, you'd have to define the job, because if there is no definition, of course any time anyone did not want to do something, he would just say, "That's not in my job specification."

Unions, in spite of many remarks to the contrary, can be extremely helpful. And they reflect the atmosphere of management.

Many times, unions exist because of your particular organization, and they will do the work *as evidenced by your attitude.* In other words, talk to the unions and insist that you get some kind of co-operation from them. If they see that you have a definite approach and way of going at things—they're going to respond that way.

I would say to the union: "We would like to have your help; if we don't have it we're going to waste a lot of time on the grievances of the employees."

The problem can be approached in many ways. I'd have to know more about the case.

Q. What can be done with an O.R. nurse who is a chronic instigator or troublemaker?

MR KOWALCZYK: Most people, by nature, like to do things as a group. A person who acts away from the group has a type of psychological ailment, you might say. I think the first job that you have is to counsel with the person to discover a reason for her actions.

All of these things cannot be solved by salve. Sometimes excision is necessary. There is no law in this country that forbids separation from the group. The old word is "firing."

Q. Where can we get further help to do our jobs more effectively as supervisors?

DR. PLANTY: Read the professional literature; there's lots of it. The American Hospital Association runs some fine training programs; and of course your own organization puts on these annual meetings. Get in on the tremendous movement for adult education. Write your state university; write your local school system, and ask: "What courses in supervision are available to us?"

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Procedure Manual No. 3— "Hilow Beds," by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom. Copies for student nurses and graduate nurse staff will be sent on request.

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303.	312a.	322.	332.	342.	352.	A-364.	A-374.	A-384.
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335. Blood-pack
336. Oxygen cylinder
337. Test tube basket
338. Needle holder jaw
339. Radiation meter
340. Respiration unit

FILMS, LITERATURE

341. Centrifuge models
342. Quantity recipes
343. X-ray equipment
344. Fire extinguishers
345. Oxygen piping
346. Pharmacy career
347. Ultrasonic cleaners
348. Vitamin deficiency
349. Plastic dressing
350. Emergency lighting
351. Haemo-Sol report
352. Sterilization film
353. Housekeeping film
354. Oxygen equipment
355. Suture package
356. Refractometer data
357. Rhinoplasty film

CONVENTIONS

C-360. Diathermy unit
C-361. Plastic coupler
C-362. Laundry formula chart
C-363. Television system

FROM THE ADS—BROCHURES, SAMPLES

A-364. American Cyanamid Co., brochure C-1
A-365. American Sterilizer Co., ultrasonic cleaning literature; bulletin SC-3
A-366. A•S•R Hospital Division, Steri-Sharp literature and samples
A-367. The Birtcher Corp., electrocardiograph brochure
A-368. Wilmot Castle Co., Castle "200" folder
A-369. Crescent Surgical Sales Co., Inc., sample blade
A-370. Davol Rubber Co., sample of Feed-Rite nursers
A-371. J. A. Deknatel & Son, Inc., sample Name-on beads
A-372. Flex Straw Co., Int'l., samples and literature
A-373. Hill-Rom Co., Inc., Procedure Manual No. 3
A-374. Franklin C. Hollister Co., bed sign book
A-375. Kremers-Urban Co., Kutapressin literature and reprints
A-376. Lehn & Fink Professional Products Corp., Tergisyl brochure
A-377. The MacBick Co., Pour-O-Vac literature
A-378. Meinecke & Co., Inc., Haemo-Sol literature and samples
A-379. O.E.M. Corp., catalog supplement 10C
A-380. Physicians Record Co., sample filing folder
A-381. J. T. Posey Co., literature on hospital equipment
A-382. Professional Tape Co., Inc., catalog and sample
A-383. Smith & Underwood, Inform control samples
A-384. Tailby-Nason Co., Inc., Betadine antiseptic sample and reprints
A-385. Edward Weck & Co., Inc., sterilizing tubing samples

300.	310.	319.	329.	339.	349.	C-361.	A-371.	A-381.
301.	311.	320.	330.	340.	350.	C-362.	A-372.	A-382.
302.	312.	321.	231.	341.	351.	C-363.	A-373.	A-383.
303.	312a.	322.	332.	342.	352.	A-364.	A-374.	A-384.
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305.	314.	324.	334.	344.	354.	A-366.	A-376.	
306.	315.	325.	335.	345.	355.	A-367.	A-377.	
307.	316.	326.	336.	346.	356.	A-368.	A-378.	
308.	317.	327.	337.	347.	357.	A-369.	A-379.	
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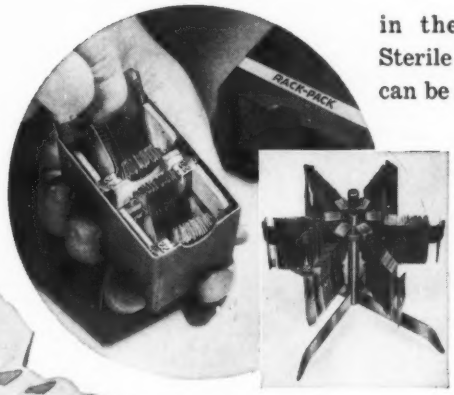

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